the MODERN HOSPITAL

VOLUME 55 NOVEMBER 1940 NUMBER 5

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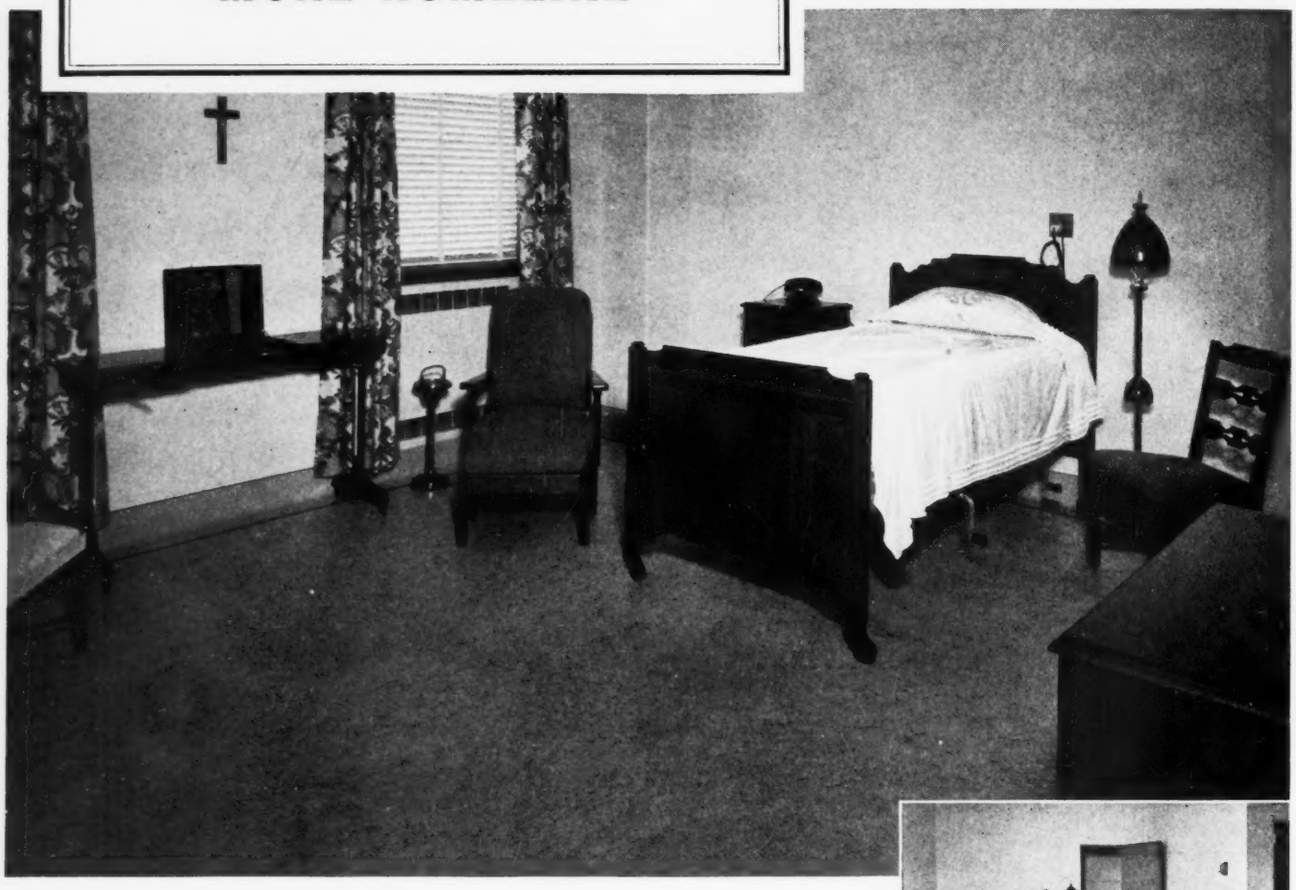

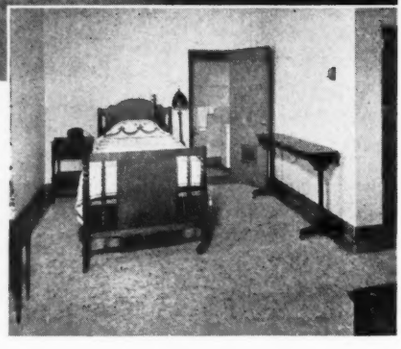

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SMALL HOSPITAL QUESTIONS

Conducted by Gladys Brandt, R.N., Cass County Hospital, Logansport, Ind.; Alloys F. Branton, M.D., Willmar Hospital, Willmar, Minn.; Jewell W. Thrasher, R.N., Frasier-Ellis Hospital, Dothan, Ala.; William J. Donnelly, Princeton Hospital, Princeton, N. J., and others

Central Supply Room

Question: Is a central surgical supply room practical in a 65 bed hospital? If so, should it be located on the floor with the surgical patients or on the operating room floor?—L. R., Ind.

ANSWER: The central surgical supply room is practical in a 65 bed hospital. Central supply is economically sound because it eliminates duplication of many special treatment trays and definitely lessens the number of ordinary bedside supplies. Central supply ensures standardization of treatments and procedures, which is essential not only for efficiency in service but for teaching purposes as well.

This department should be located on the operating room floor for reasons of economy. For example, the central supply room would have to be equipped with an autoclave, water sterilizer and water still if it were located apart from the operating room, which is already equipped with these essentials, and a duplication of such equipment would be financially impossible for many small hospitals. Because of its close association with surgical preparation and surgical procedures, the central supply department should be considered a definite part of the operating room and it can easily be managed and supervised by the operating room supervisors with only a small addition in personnel.—F. D.

Cantankerous Employes

Question: What should we do with employes who have given long and faithful service but now are getting cantankerous and shiftless? We are a hospital of 70 beds.—C. W. E., N. Y.

ANSWER: 1. Have a heart-to-heart talk with them. They may be unaware of their attitude and its reflections. They may be fearing dismissal on account of their age or the ambitions of the younger element in the organization, and are confused and afraid about the possible outcome. An assurance that if, and as long as, their performance is of high quality they have nothing to worry about may change their outlook. Tell them frankly that their attitude is bad for the hospital and worse for themselves. If possible, try to determine why it exists. Maybe there is a cause that can be removed or adjusted.

2. Depending upon the outcome of the interview, give them a complete physical examination, including whatever laboratory work and x-ray examinations may be indicated, to rule out incipient disease.

3. If they have been satisfactory employes for a long time, a longer-than-usual vacation or leave of absence may be the cure. After many years of work, a good rest and complete change of atmosphere and environment may be all that is needed. Perhaps vacations have been too brief.

4. Transfer them to another department if that is feasible.

5. Encourage them to develop more outside interests; suggest several. Their home life may be dull.

6. Advise them to visit other hospitals and see how people are filling jobs similar to theirs. This almost always inspires hospital workers to renewed interest in their own jobs.

If the interview is satisfactory and promising enough to justify any one or more of points 2 to 6, try them out for a period of about three months.

If the interview is hopeless or if, after a three months' period of observation, there has been no evidence of improvement or not enough to pin hopes to, there is nothing left but termination of employment. If nothing at all is done, the hospital will gradually accumulate a number of mediocre and incompetent employes whose attitude will be reflected in the performance of all of its personnel.—C. S.

Medical Staff Rules

Question: What can we do to get our doctors to cooperate in observing the rules of the hospital, e.g. regarding preoperative diagnosis or requiring the presence of a second physician at operation?—L. M. B., Ind.

ANSWER: The first step in establishing any hospital rule governing doctors is to have the staff approve it. If it is a ruling that is likely to meet with resistance, it is well to have it approved also by the trustees so that you will have their backing if necessary. Then take pains that the doctors are well informed in regard to it. While the matter should be handled as agreeably as possible, it is the duty of the superintendent to enforce all staff rulings; there should be no exceptions and no favorites. No individual doctor should be allowed to disregard the ruling, which should be enforced absolutely—even to the extent of not allowing an operation. Once will probably be enough. It is vital that the authority of the hospital be recognized. If you once get established in the minds of staff men and nursing personnel the idea that staff rules must be observed, hospital life becomes much more peaceful.—K. J. H.

Board's Prerogatives

Question: What are the active duties that trustees should perform in a 45 bed voluntary hospital?—E. H. L., Texas.

ANSWER: The active duties of the trustees of a small hospital are identical with those of a larger institution. The board is a legislative body and its orders are executed through the director of the institution. The trustees personally approve budgets and expenditures since they are responsible for hospital finance. They give final endorsement of appointments to the medical staff. All other activities are through the director of the institution, who should keep them informed of everything that occurs.—J. T.

Student or Graduate Staff

Question: Is it cheaper to maintain a school of nursing or graduate nursing service in a 65 bed hospital?—F. L. A., La.

ANSWER: Regardless of statistics, much depends on the construction of the building, the location of the hospital, the availability of graduate nurses and the number of maids or aids used.

Probably the cheapest type of nursing service is the graduate nurse service with sufficient maids or aids to do all work that is not strictly nursing. It is not always the cheapest nursing service that is the most satisfactory, however. The small hospital that does not have convenient educational facilities will find meeting the requirements for accreditation a financial burden that is rarely justified.—J. T.

Breakage of Drinking Glasses

Question: We use steam sterilization for our water glasses and have a high breakage. How can we cut down on this breakage rate?—M. S., Okla.

ANSWER: You are probably using glasses that are of an inferior quality and cannot withstand the heat. At the present time there is on the market a medium weight, moderately priced glass that can stand a great deal of abuse, as well as the necessary steam sterilization.—J. T.

LOOKING FORWARD

The Intern and the Draft

IN CONSIDERING the rearmament program, it would be well to take a long view. There is at least a reasonable probability that the conditions that have caused this nation to rearm will continue for several years. Sound planning should not assume that the present emergency will obtain for a mere space of a year or so.

This fact has an important bearing upon the position of junior and senior medical students, interns and residents who are now preparing themselves to become the physicians of the future. If the training of these men is suddenly broken off in mid-course, they will be of only nominal value to the government. Their potential abilities as physicians cannot be utilized until they have finished their internships.

Clearly, it should immediately become the settled and universal policy of the federal government to keep medical students and interns at their studies until they have completed at least the internship. This is but simple economy of human resources. It is a protection to the civilian, as well as to the military, population. It is good to learn that steps are being taken to commission interns as officers in the medical reserve corps and to return them to their internships so that they may complete their training. Similar steps should be taken regarding medical students.

In the training of residents the issues are not quite so clear cut but are equally important. In the United States the residency is now in the process of becoming the most effective method of training qualified specialists that the country has ever had. The Army, as well as the civilian population, has need of such specialists. In the long view, it will be decidedly to the advantage of everyone to allow as many physicians as possible to complete their residencies.

Hospitals will, of course, cheerfully make whatever sacrifices are essential to adequate national defense. But because they are in a peculiarly good position to appreciate the value of well-trained physicians, they should make their voices heard in the demand that adequate provision be made for the medical profession of the future.

New Commissioner of Hospitals

UPON Doctor Goldwater's retirement as commissioner of hospitals of New York City on October 1, Dr. Willard C. Rappleye, dean of the College of Physicians and Surgeons of Columbia University, accepted appointment as his successor for at least the remaining fifteen months of Mayor La Guardia's term. Doctor Rappleye has been granted a leave of absence from Columbia for the period.

Thus, through Doctor Rappleye's public spirit, a difficult situation for Mayor La Guardia is solved. What will happen at the end of the mayor's term is as yet quite uncertain.

The New York commissioner of hospitals has under his direction institutions containing more than 20,000 beds, as well as dispensaries that provide approximately 3,000,000 clinic visits per year, and nurses' residences, staff quarters, employes' dormitories, laboratories and other necessary buildings. In each of 36 states of the Union, according to the latest register of the American Medical Association, there are fewer hospital beds than there are in the hospitals directed by the New York commissioner. The tax levy budget for the department for a recent year approached $27,000,000. A six year building program outlined by Doctor Goldwater in 1938 called for the expenditure of $99,854,000 in the period from 1939 to 1945, inclusive.

The importance of this department cannot be measured in terms of buildings and patients alone. It is tremendously significant in the fields of education for nurses, interns, residents and practicing physicians. Under Doctor Goldwater's stimulating leadership the department has made rapid strides in the quantity and quality of research undertaken in all aspects of

medicine, especially in the field of the chronic diseases.

As an employer, the department of hospitals ranks with big business. Approximately 20,000 persons are employed by the department and between 5000 and 6000 workers serve without pay or are paid by private funds. These do not include several thousand persons whose service has been provided to the department by the W.P.A. and other governmental organizations.

In view of the tremendous responsibility involved in administering the New York City department of hospitals, the commissioner's salary of $10,000 is pitifully inadequate. The true compensation for men like Doctor Goldwater and Doctor Rappleye is the satisfaction they feel in the knowledge that through their efforts several hundred thousand sick poor each year are given the best hospital service the city can provide and that a million or more out-patients are able to turn to the city for aid in their time of need, confident that help will be forthcoming.

Protecting the Drafted Employes

UNDOUBTEDLY, some employes of hospitals will be drafted. How can their jobs be retained for them? It is suggested that a person who is employed to take the place of one drafted be asked to sign a statement acknowledging that he is aware of this situation and expects to surrender the position when its former occupant returns to civil life.

Some hospitals will wish to go farther than this and protect their drafted employes by maintaining their life insurance and their hospital care insurance and even by paying some of the difference between their regular salary and their Army pay. Insofar as their finances permit, hospitals should attempt to treat employes as generously as do business concerns.

Nurses and the Army

THE enrollment of several thousand additional nurses in the Army, Navy and Red Cross would not be a serious matter were the supply of nurses plentiful. Actually, however, this emergency demand comes at a time when the normal requirements for nurses have been growing at a pace that equals or exceeds the increase in the supply.

In 1936 there were 18,600 graduates from the 1472 nursing schools then in existence. In 1940 there were 23,600 nurses completing their work in 1303 schools. The additional 5000 nurses was a substantial and welcome increase in the supply. From the reports of hospital administrations, however, the increase was none too large.

At the Boston convention of the American Hospital Association, Dr. Winford H. Smith made two excellent suggestions. He urged, first, that all qualified schools of nursing should immediately increase their student enrollment by at least 10 per cent if possible. He also urged that a special committee, representing hospitals, nursing groups and the Army and other federal agencies concerned, should immediately be set up to outline a curriculum for the training of ward aids. He stated the belief that such a curriculum should not be as short as the six weeks' training now offered in England or as long as the nine to twelve months' training previously suggested by the nursing organizations. Somewhere between these two extremes, he felt, a happy medium could be discovered that would give the aids enough training to make them of real service to hospitals and yet would turn them out in sufficient quantities to meet the impending emergency.

It is important that action on these proposals be taken promptly. The nursing groups have already set up a Nursing Council on National Defense which represents not only the nursing groups but also the Army, Navy, Red Cross, Public Health Service, Veterans' Administration, Bureau of Indian Affairs and other interested organizations. The functions of this council have been listed as follows:

1. To determine the rôle of nurses and nursing in the program of national defense.
2. To unify all nursing activities that are directly or indirectly related to national defense.
3. To study nursing resources; to plan the most effective use of these nursing resources; to provide for necessary increases, and to set up the machinery that will ensure the greatest possible functioning in case of need.
4. To ensure the continuance of the high quality of nursing schools and services in order that effective nursing may be maintained in times of national emergency.
5. To act as a clearing house regarding nursing and national defense and to cooperate with other agencies having related activities and functions.

Such a group would doubtless be glad to work with the American Hospital Association on the problem of obtaining an adequate supply of nurses.

Licensing Hospitals

THE recent publication by the A.H.A. council on governmental relations of a suggested licensing law for hospitals and clinics (Bulletin No. 201) comes at an opportune time. In all parts of the country hospital administrators and even some trustees are considering seriously the need for such legal control.

At present in most states anybody can rent a residence, employ a graduate or "practical" nurse and call the resulting establishment a hospital. Except through the sanitary or fire laws, if any, there is no control over the formation of such an enterprise. In a few states there are minimum standards applying to maternity hospitals but not to other types.

This situation, in some states, has led to the development of many small, inadequately staffed and inadequately equipped institutions where the principal desire seems to be to make it possible for physicians not properly qualified to practice surgery to perform surgical operations. In other situations, the result of this wide-open policy has been the building of additional hospitals in areas in which they were not needed, while other areas that are in real need of increased facilities are unable to obtain them. A properly drawn and intelligently administered licensing law should rectify both conditions.

In any consideration of licensing, of course, the hospitals should not take a narrow attitude, attempting to choke out possible competition. They should view the situation from the standpoint of the greatest good to the whole community, giving full recognition to public needs for hospital service.

The House of Delegates

ALTHOUGH no one wants the affairs of the American Hospital Association to be run on an autocratic basis, it would seem that the work of the house of delegates could profit by more careful advance planning.

On numerous occasions during the recent Boston session, the delegates were hampered because subjects came up for discussion when the persons officially most directly concerned were not present. This was particularly noticeable on Wednesday afternoon when the relations of the A.H.A. to the hospital service plans were under discussion. The chairman of the commission on hospital service, the chairman of the council on hospital service plans and the president-elect were occupied elsewhere. Even the important resolution on this subject that had been adopted by the board of trustees was temporarily not available while a motion to approve it was being discussed.

Doubtless, the officers of the A.H.A. are fully conscious of these problems. There was discussion of the need for a parliamentary officer to assist the chairman. Far more important would be the preparation of a carefully integrated program with adequate assurance that those persons directly concerned with the various parts of the program would be on hand to participate when they are needed.

Health Benefits of the Draft

THE physical examination of several million young men as a result of the draft offers opportunity for positive health gains. If the physical examinations of these men are made carefully and if the results are then utilized both for research and for treatment, there should be a definite improvement in the health of the nation.

Thousands of heretofore undiscovered cases of disease, such as tuberculosis and syphilis, should be brought to light in the medical examination of the draftees. What will happen to these persons? Will they be informed of their condition or will the information be sent to their personal physicians? Will health authorities be notified of the existence of reportable diseases? Will positive steps be taken to ensure that treatment is available to those who need it?

In addressing a recent special conference of the state and territorial health officers, Dr. Thomas Parran, surgeon general of the United States Public Health Service, emphasized that "in preparing a total defense, all factors ultimately rest upon the one fundamental resource of the country—manpower."

He pointed out that planning should be done on a long-range basis. What is done to improve health, if well done, "is imperative for safety in war but is even more greatly productive for permanent peace. Whatever the future holds for us, our effort cannot be wasted. We build for a strong, a vigorous America, eternally ready for tomorrow."

Universal First Aid Training

THE first aid training that the American Red Cross has given to the civilian population in times past is an excellent safeguard against emergencies. At the present time, when the country may face new and unknown trials, it would be well for such training to be made universal.

School children in the upper grades and adults of all ages might well be given rudimentary drill in first aid. If this country is drawn into war and our own seacoast areas are subject to possible attack, such experience would be invaluable. If we escape war, there is still a large number of accidents and emergencies in civil life in which a knowledge of the elements of first aid would be valuable.

Hospitals might well cooperate with the American Red Cross by organizing classes, providing facilities and even by helping recruit the teachers for them.

Improved Library Service

THE American Hospital Association library committee, with the warm cooperation of the board of trustees and the headquarters staff, is making definite improvements in the service of the Asa S. Bacon Library. Several hundred dollars have been expended in the purchase of new books and periodicals. As an experiment, the library will now circulate books on a fourteen day, nonrenewable basis. A list of the newly acquired books appears in *Hospitals* for September. It is hoped that many people will take advantage of this liberalized policy. The committee and trustees will watch the results with interest.

Modernizing

WILLIS J. GRAY

RESTYLING a hospital may take two forms: improvements in physical appearance and equipment and improvements in service. For the past few years the Charles Godwin Jennings Hospital in Detroit has been carrying on improvements of both types simultaneously.

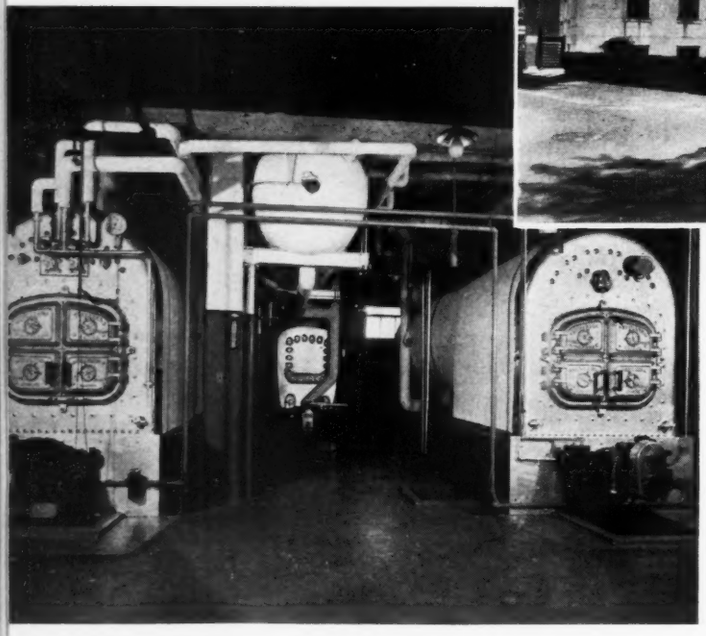
Ours is not an old hospital yet in any institution erected 10 years ago, as this hospital was, the modernization of plant and equipment must keep pace with medical progress and with the increasingly exacting demands of the public.

The four story fireproof structure occupies an area of 55,000 square feet and is T-shaped in plan. The first three floors of the wing are given over to doctors' offices. Regular members of the hospital staff occupy the 14 suites. Patients and physicians are impressed with the numerous conveniences of such a setup and the arrangement benefits the hospital in many other ways, not the least of which is the additional revenue in the form of rent. This revenue has proved sufficient to render this hospital self-supporting.

Left: The main lobby of the hospital, showing the interior wall decorations and the new corrugated matting.

On April 1, 1939, the hospital established a uniform system of inclusive rates for all in-patients. Under this system the patient receives a maximum amount of service at minimum cost and he can calculate in advance just what his hospital bill will be. Physicians can make a more definite diagnosis without incurring additional expense and the hospital profits by being assured of a regular income for its special services. The charges for special services amount to $39 distributed over the first eight days of hospitalization. Particular rates apply to maternity and tonsillectomy cases.

Right: The Seyburn Avenue entrance of the 78 bed Charles G. Jennings Hospital, Detroit.

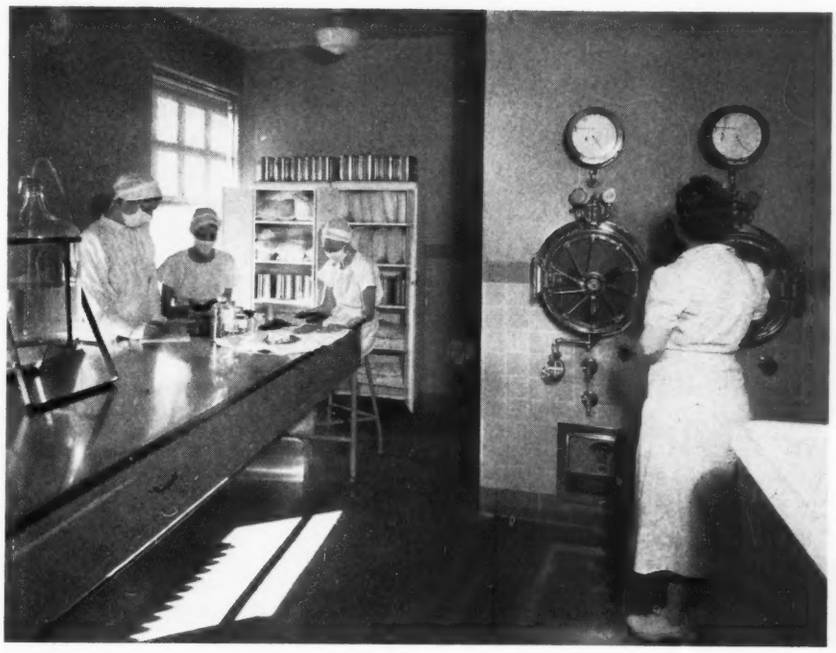


Left: Power plant showing 100 h.p. boilers, each with a 100 h.p. oil burner, and combined waterheater and incinerator.

During the last two years we have given considerable thought to problems of interior decoration. Our entire hospital has been redecorated and now presents an environment that is conducive to comfort and rest-

a Modern Hospital

Superintendent
Charles Godwin Jennings Hospital
Detroit



The central supply and service room is one of the features of the hospital's modernizing program.

fulness. Lobbies, consultation rooms, examination rooms and laboratories are decorated in a soft blue green. Corridors are in pale peach, with a light ivory enamel trim. In the four surgeries, situated on the fourth floor, the walls are finished in a light pastel green, which harmonizes with the pale green baseboard tile. Patients' rooms have been redecorated in apricot, gray blue, peach, powder blue and oyster gray. The color schemes have been favorably received and, not infrequently, prospective patients have selected certain rooms because of particular color schemes.

It may be explained that all wall decorations consist of one coat of stippled flat wall enamel of a high grade, which makes for a durable surface. We have found that one coat of a fairly heavy consistency suffices for an attractive appearance if it is stippled and will hold up under repeated washings. Wooden cornices finished in pleasing and restful colors have been added as a part of the room decoration in all the patients' rooms. These have an assuasive effect upon the entire color scheme and harmonize well with the wall decorations.

Floors in the lobbies and the corridors are covered with rubber tile in patterns of brown, black and antique ivory; baseboards are of terrazzo. Floors in patients' rooms are laid with mottled gray and brown linoleum. Both the rubber tile and the linoleum are economically maintained by the use of water wax. A practical improvement, made about a year ago, was the acquisition of corrugated rubber matting for the lobbies. Previously, during bad weather, the continuous traffic of wet feet through the building presented a situation difficult to cope with from the point of view of cleanliness; the waxed surface on the rubber tile became slippery, and this condition led to some fairly serious accidents.

Patients' rooms are appropriately fitted out with wooden furniture in modern design of two distinct finishes. The furniture in private rooms consists of bed, bedside table, dresser, desk, lounge chair and straight chair, all finished in brown mahogany. A new improvement in these rooms has been the acquisition of a modern overbed adjustable table. This table is a combination of vanity and bookshelf, which adds materially to the welfare of the patient and replaces the old style bedside shelf, which served as a part of the bedside table.

Semiprivate rooms (accommodating two patients) are fitted out with somewhat similar furniture finished in maple, except that there is no desk or dresser. The tops of the bedside tables and trays have a synthetic plastic material adherent to the surface which is alcohol and acid resisting. All rooms are provided with spacious clothes closets and individual or connecting toilet and lavatory facilities.

Besides the accessories customarily supplied, we have added as part of our standard room equipment a stainless steel vacuum bottle with a tray, in color, to match the water glasses. These bottles, though expensive, have more than once demonstrated their utility.

Because they are not too remote from oil wells, many hospitals in this locality seem to be oil-minded. For seven years we used light oil at a cost of 7.1 cents per gallon as the chief source of fuel for domestic heating. Since the cost for power plant operation appeared to be extremely high because of the cost of fuel oil, it was deemed desirable to make an exhaustive study of solid, liquid and gaseous fuels that are adaptable for hospital use. After a six months' study, we arrived at the conclusion that heavy oil, costing 3.5 cents and giving 141,000 Btu. per gallon was a more economical fuel to burn.

To change the entire system necessitated complete repiping of all oil lines; the installation of a hot water preheater, which is connected directly to the main hot water system, and a twin suction pump installation for the circulation of oil.

The new system functions most economically. Oil at a temperature of 130° F. is atomized at the burner and the preheater system is capable of circulating sufficient oil back to the main storage tank to maintain a constant temperature of 100° F. for recirculation within the storage tank. The installation was completed at a total cost of $2430. We found that the savings in fuel alone during the year 1939 amounted to $1429. From this savings we were able to purchase a second heavy oil burner and incinerator combined at a cost of $1075.

A typical patient's room fitted with wood furniture of modern design.

The second oil burner was installed in a separate boiler and is held in reserve for emergencies.

A recent development of some significance has been the establishment of a central supply service on the fourth floor opposite the surgery. The importance of a good system of central supply cannot be overemphasized. In a new hospital, the plans of construction usually provide for separate quarters which are given over to the exclusive use of central supply activities. To find available space in the older hospital, however, is not easy, especially if much equipment is needed in setting up the system in order that it may function to the best advantage. It is considered good practice to place the central supply service either adjacent to the surgery or in a section of the surgery quarters because of the large amount of sterilization that is neccesary.

Every hospital has a supply room where bandage materials and, perhaps, various solutions are prepared for the whole hospital. Some hospitals have found it to their advantage to expand the facilities so as to include all of the special trays that are ordered by the doctor, which formerly were cared for in the utility room on the floor. Central supply service in any hospital is without doubt a step in the right direction.

Efficiency and uniformity are promoted in setting up the various types of tray services, because all supplies and details are reserved to specially trained nurses.

Following the development of the central supply service we found that less equipment was needed than under the old system in which all floors had to have one or more sets for each kind of tray service. This, naturally, represents an actual saving to the hospital, because duplication of equipment is eliminated. Practically every important tray procedure that was formerly arranged on the floor is now done in the new central supply room.

In order to provide more shelf space, two large white enamel cabinets were purchased, together with a liberal supply of stainless steel containers for gauze and cotton to use in the dressing baskets. Gauze was formerly purchased in 100 yard bolts and cut into four by four squares. The realization that sponges, cut to the exact size, could be purchased just as cheaply prompted us to change to the ready-cut sponges. An inexpensive power needle sharpener was obtained which has shown amazing results in the efficiency of needle care and in savings in the cost of needles. Much more time is now available to the floor nurses, which is used to improve actual bedside care.

In the small hospital one naturally expects that the service in the maternity department would be carried on in a small way in keeping with the general activities of the institution. Maternity service, however, is one that should be encouraged inasmuch as a friendly sentiment toward the hospital is usually evoked in the parents, which becomes a lasting impression of good will. Utmost care and protection should be given to the new-born infant, and the hospital, therefore, should provide itself with all of the modern appliances that make for safe and sanitary technics.

In view of these factors, it was felt that plans should be evolved for expansion and improvement of this service. One of the large two bed rooms on the fourth floor was given over to nursery quarters. The room was entirely redecorated in white enamel, which made it most attractive. A second two bed room adjoining the new nursery was developed into a labor room. It is equipped with two beds that have side rail protection and is fitted out with all of the essentials for proper preparation. The old surgery now serves as an excellent isolation room for infants.

The equipment provided in the nursery consists of a new automatic incubator and new white enamel bassinet stands. These stands have been especially designed with compartments at the bottom for all of the infant's wearing apparel as well as its toiletries. Two oxygen therapy canopies, two light cradles and resuscitation apparatus are immediately available in case of emergency.

A year ago a health service for employes was instituted. It was believed that some employes were not well and that new personnel was being hired that was not physically fit. Physical examinations were undertaken by our internists during regular office hours for all employes. Three cases of grave illness were discovered and these employes have been saved much mental as well as physical discomfort because of early diagnosis. This health program consists of a complete physical examination, an x-ray of the chest and examination of the teeth. Special examinations are made if the employe's condition appears to warrant it.

The hospital has profited by the new health service in cutting down the number of absences resulting from illness. We know now that there is no one working for the institution whose physical condition might prove harmful to patients or to other employes.

Observations on Autocracy

R. D. BRISBANE

Wherein the half-pint Hitlers take a verbal beating at the hands of Mr. Brisbane, whose sentiments may not win him friends but may, on the other hand, influence some people who need to see the error of their ways

WISECRACKING motorcycle officers, the tough cop and the hard-boiled sergeant of the awkward squad are the usual examples in the American mind of misplaced authority. However, many hospital employes have personal nominees as well, for they know too well how a bit of authority brings out the tyrant in some whose education should teach them better.

In many hospitals the supervision of employes is left to haphazard methods that show little improvement over those of the logging or construction boss of 60 years ago who ruled with his fists or with a peavey handle. Now the brow-beaten employe does not even have the chance to proclaim his innocence publicly in trial by combat, and only a native of Cork or a Billingsgate fishwife could fend off some of the petulant nagging and sarcasm dealt out to underlings.

Probably the following personal observations of "bosses" could be duplicated in many other hospitals, and in business organizations, as well:

The department heads who "get even" with their subordinates because of personal grudges that have nothing to do with employment. These, we are sorry to state, are often members of the deadlier of the species. At the expense of ostracism or even worse, we must state further that in nearly twenty years of hospital endeavor we have known only two women in institutional supervisory positions, in charge of more than 10 employes, who did not let personal bias affect their judgment of what constituted an efficient employe. As the author of "As I Remember Him" remarked, "Most supervisors of nurses get to be little female Caligulas. They must have been nice girls once!" One of the strangest vagaries of human conduct is the reaction of the subordinate of some of these petty autocrats who, as soon as she is promoted, immediately proceeds to become as tyrannical as her predecessor.

The administrator who withheld pay checks for disciplinary effect.

The night supervisor found sleeping half the night while the other nurses carried on her duties.

A surgery supervisor whose sarcastic tongue had all her force in tears about every two weeks and who thought her position so secure that she could call up any of the other department heads, harangue them for shortcomings and then hang up in the other person's ear. Then there was another supervisor who bought farm products from some of her nurses and consistently forgot to pay for them.

The family clique, such as the husband as manager and the wife as superintendent of nurses, with the erring student nurses or employes caught between the upper and nether millstones. One combination included the father as chef, the wife as salad cook and the son as night cook, with the usual repetitious menus and food not fit to eat.

A chief engineer who took his Sundays off regularly but made his subordinates work seven shifts a week. Another frequently made his men wait an hour or two on their own time until he arranged the following week's schedule.

The chief technician who arranged duties and hours at the expense of others although she was supposed to bear an equal load and her share of night calls.

The laundryman who smoked on duty but allowed none of his employes to smoke.

A chef who had one kitchen maid stand behind his chair—evidently to keep off the flies—while another maid served his meal in courses! It actually happened.

One little man with a big wife who wore the family authority; he took it out on those in his charge, perhaps to satisfy his ego and to bolster his masculine pride.

The manager of a hospital who frequently had such bad hangovers from the night before that no one dared to get in his way or cross him for two days thereafter.

Department heads with chronic indigestion whose tempers and acid tongues varied with their stomach pressure.

Religious misanthropes whose herculean labors with the world and the flesh left them too exhausted to be civil even to their own families.

Left: The tough "cop" has some excuse for existence; the tough administrator or department head hasn't. Below: An employe wresting her check from the administrator by brute strength.

Mr. Brisbane is superintendent of Sutter General and Maternity Hospitals, Sacramento, Calif.

Left: "The morning after the night before." Center: Watch dog of the treasury. Right: It's a good racket.

Misers who were apoplectic for a week over the loss of a 25 cent thermometer.

And, finally, the racketeer who encouraged gifts from subordinates for birthdays, anniversaries, holidays and other occasions. Often some pet of a department head starts the ball rolling and, no matter how the others hate the superior, they feel that their position depends upon their donation. Many can ill afford the amount expected but it has to be paid under pain of being called a piker.

Of utmost importance in this connection is the let-down engendered in discipline. No department head or supervisor feels like reprimanding an employe who but yesterday helped buy him a beautiful traveling bag or desk set. Naturally, the employe expects a certain amount of "protection" because of the gift, which starts another vicious circle.

Undoubtedly, there will be many disagreements with this sentiment but, if the subject is thoroughly analyzed, we believe most emphatically that the only conclusion will be that no presents whatever should be given to, or accepted by, anyone in authority. The only exception might be when an employe has given many years of long and faithful service to an organization and is retiring. At such a time no one will feel that he will lose his position if he still dislikes the "donee" and fails to contribute.

Another factor that contributes to unhealthy supervisory conditions is the large number of persons in positions of authority who are near to or over what would be the retirement age in an efficient organization. This is especially true of public hospitals under civil service and of denominational or endowed hospitals where the absentee management of ecclesiastical authorities or the influence of wealthy philanthropists keeps on for years superannuated sycophants who could not last as long as the proverbial snowball were it not for their friendship at court.

Every experienced administrator knows the mean, despicable, pettifogging, domineering dispositions developed by employes who cannot be fired without an act of Congress. No department or institution can operate efficiently when persons with prima donna complexes must be served before anyone else. This is no diatribe against older employes but only against those who have sunk so far in an institutional rut that they have lost all sight of their mission of mercy to the suffering and become "little tin gods on wheels."

Another sinister spore of "bossism" is found, moreover, in denominational hospitals where they are more concerned with sending in their yearly contribution to headquarters for the conversion of the distant but glamorous heathen than in keeping their Christian personnel from slipping off the path of virtue by some charity that is supposed to begin at home. Low wages, which in some instances approach serfdom, atrocious food and other working conditions that still exist in some institutions would drive even a saint to the devil for a full stomach once a month. If you are skeptical, ask the ones who have worked there.

Leaving out the Christian ideals of reward in this world or the next, leaving out the Golden Rule and every other humanitarian consideration, the stark law of cause and effect alone should arouse us to eliminate every petty introvert from our pay rolls. For, if they are wrecking the happiness of employes in their own and other departments, we can be certain that our guests are the ones who are eventually affected and driven from our doors. Every hasty, cross word of the management staff is reechoed from front door to kitchen through the rank and file, endangering the hospital's chance for usefulness in the community, its opportunity as a center for healing and its financial success.

In the large army of hospital personnel, it is our duty as supervisors, department heads and administrators to see to it that adequate wages, reasonable hours, ample, wholesome food and cheerful unbiased oversight are given to all, including the latest, lowliest employe. Furthermore, if we are to fill the rôle of constructive leadership competently, we must, first, keep physically and mentally fit and alert; second, study and analyze our daily tasks that we may lead and not try to drive others to their duties, and, finally, just be gracious, considerate and helpful to the other fellow, no matter what his position. Perhaps we were there once. Perhaps we'll be there again. Who knows?

Humanity of a Hospital

Here is another way of judging character in the conduct of the acute general hospital. It consists of reviewing periodically the kind of "clinical material" which the general hospital transfers to other institutions, such as almshouses and other custodial institutions, h o s p i t a l s for chronic cases and convalescent homes.

Hospitals that have a sense of responsibility and a conscience will show a high percentage of retentions during illness that requires active hospitalization, while those that do not possess these humane characteristics will show a large percentage of premature transfers. The surgeon who recommends the transfer of a patient after a first stage prostatectomy, to give only one illustration, "because of the long drawn out chronic character of the condition," is either incompetent, in which case he should not have started what he could not finish, or irresponsible. In either case the administration must share the guilt.—E. M. Bluestone, M.D., *director, Montefiore Hospital, New York.*

Hospitals Plan for Defense

MALCOLM T. MacEACHERN, M.D.

THE measures that are now being taken by hospitals as part of their share in the work of the national defense program include the organization of 59 war hospital units. Some 1500 physicians and surgeons now on the staff of these medical schools and hospitals have applied for commissions in the medical corps reserve of the Army in order to qualify as officers of their units when and if the units, which will be equipped by the Army, are called up for active service.

Supplied Units in 1917

Institutions that have been asked to form units are, in general, the same that supplied units for hospital service overseas in 1917 and 1918 whose performance was so valiant and satisfactory that the War Department is now eager for preparedness of the same type from the same sources.

In the World War, the units were organized through the American Red Cross and they equipped themselves. Present plans of the War Department call for 62 units, 32 of which are to be called general hospitals, 17 evacuation hospitals and 13 surgical hospitals, each bearing the name of the sponsoring institution and serving as an affiliated unit of the medical department of the Army. Ordinarily, one field army has 10 surgical hospitals, 12 evacuation hospitals and one hospital for convalescent cases.

The general hospitals are out of the zone of operations and about 50 of them with 1000 beds each are required for each field army. Airplane ambulances and landing fields for them are factors to be considered in planning the locations of present day general hospitals.

So far, the organization work has not gone much beyond selection of officer personnel, with nurses, enlisted men and technicians to be enrolled for the units later. The purpose of organizing the units at this time is to assure the advantage of having men who are used to working together continue to do so under the stress of war conditions, if they materialize.

Presentation in detail of the plans of the War Department for medical and hospital participation in the defense program was made at the hospital standardization conference of the American College of Surgeons in Chicago on October 21 by Surgeon General Ross T. McIntire of the United States Navy. The organization of a typical unit was described at the same session by E. W. Jones, director, Albany Hospital, Albany, N. Y.

Doctor MacEachern continues his discussion of the hospitals' contribution to national preparedness with a description of the war hospital units that are being organized by 59 hospitals and medical schools

So much for preparation for participation in the military aspects of war if it comes. Three score or so of our largest hospitals and the medical schools with which some of them are affiliated are taking care of this for the time being. The remaining 6166 hospitals cannot commit to them, however, the entire burden of national defense.

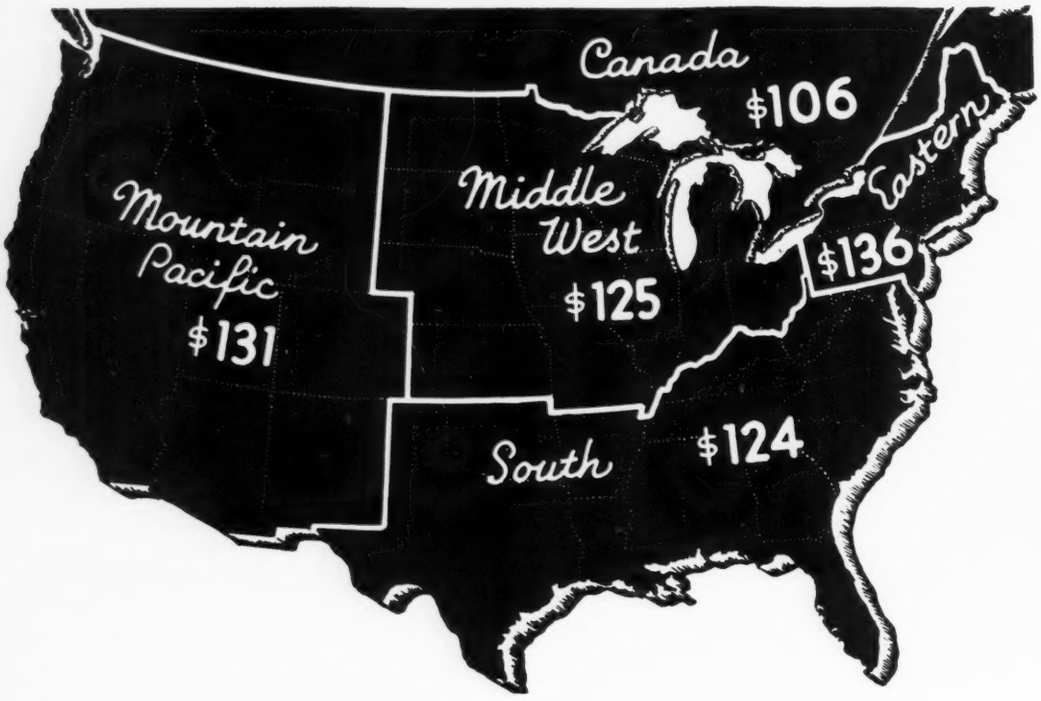
National defense is designed to prevent war, not to invite it, and a large part of the value of the program lies in strengthening ourselves and in exhibiting evidences of that strength for the benefit of aggressor nations. For this, good health is basic. Hospitals will, therefore, concur with Surgeon General Parran's conception of preparedness as a program that is much wider than the formation of war hospital units. Patriotism demands anticipation of government needs and wishes for intensification of hospital service in every community, both rural and metropolitan, throughout the whole country.

A specific example of a way in which any hospital, small or large, can help is furnished by an institution in a small community which a couple of years ago formed a nurses' club, with the idea of providing social and professional contacts for nurses in the locality who were not near enough to their nursing schools to be able to make contacts with other alumnae.

When the defense program was started, it became evident that here was a good source of additional nursing material. Several nurses who have married and ceased to practice their profession are taking refresher courses in the hospital and are planning to register for service if needed. This idea, which was described at the hospital administrators' institute in Chicago in September, may be extended to include technicians, dietitians and other specialized personnel, as well as recently retired physicians who will be valuable for home duty in an emergency.

Must Analyze Own Needs

Each hospital must analyze the needs and possibilities of its own community and intensify its efforts to meet peacetime conditions so well that no catastrophe, be it earthquake, fire or flood, will find it unprepared. Out of extraordinary effort to meet conditions as they arise, including the changes caused by expanding industrial activity, will come a large part of the necessary preparedness for possible war. If by such effort coordination to a degree stronger than hospitals have before attempted is accomplished, the hospital will be ready for its important rôle in the national defense program.



Size of hospital apparently has more bearing on the salaries paid to nursing supervisors than does geographical location. Average salaries in small hospitals are $113 whereas in large institutions the average is $173.

Hospital Salaries—Nursing Supervisors

ALDEN B. MILLS

THE average income of the nursing supervisor in the nongovernmental general hospitals of the United States, Canada and the insular possessions is $128 per month.

This is the figure obtained from returns on incomes of 922 supervisors, taken from schedules sent in by 1402 hospitals. Three hundred and thirty-five of the 480 hospitals that did not give information have fewer than 50 beds. Only 223 hospitals of less than 50 beds reported figures for nursing supervisors,, indicating that propably less than half of the hospitals of this size employ such a department head.

As in the previous articles in this series, the salary tabulated is the sum of the cash salary plus an estimated fair value for maintenance. When figures on the value of maintenance were furnished by the reporting hospital, these were used unless they were obviously erroneous. When the hospital reported the amounts and kinds of maintenance but did not put a valuation on it, the various items were valued as follows: room, $10 per month; board, $30 per month ($10 each for breakfast, suppers or dinners), and laundry, $5. Undoubtedly, there are certain unfairnesses in this arbitrary valuation put upon maintenance, but it probably represents a reasonable average and the number of reports is sufficiently large so that the cases in which this figure is too low probably cancel those in which it is too high. To omit the value of maintenance altogether would vitiate the value of the figures far more than to include it arbitrarily.

The average income of $128 per month conceals many differences. In the various geographic regions, for example, the average incomes were as follows: Eastern (including New England and Middle Atlantic states), $136; Middle Western (including East North Central and West North Central states), $125; Southern (including South Atlantic, East South Central and West South Central states), $124; Mountain and Pacific, $131, and Canada, $106. (The insular possessions of the United States are included with the nearest section of the mainland.)

With the exception of the salaries paid in Canadian and Eastern hospitals, however, the variations by region are relatively less significant than the variations by size of hospital. As will be seen in the accompanying table, the Canadian salaries for nurse supervisors are usually low and the Eastern salaries are frequently high (in four of the seven groups). But the range from the average of $113 per month in the small hospitals to $173 in the institutions of 500 beds and over is far greater than the difference between the highest and lowest in any particular size group.

The range in salaries is indicated roughly by the fact that four of the 922 reports pay salaries of from $60 to $69, while, at the other extreme, six reported salaries of $200 and over. It may be that part of the differ-

ence in salaries reported arises from differences in interpretation of the term "nursing supervisor." When the questionnaires were sent out the committee on personnel relations of the American Hospital Association had not yet issued its report on "Job Specifications for a Hospital Organization." This report defines the duties and qualifications of the nursing supervisor as follows:

"Duties: Under general direction, to have responsible charge of a major nursing service including two or more divisions; to plan and carry out a teaching program for student nurses assigned to the service; to assist with the teaching of head nurses and staff nurses; to have charge of special nursing functions, and to perform related work as required by the director of nurses.

"Examples: Being responsible for the teaching program which is carried on in a major nursing service; directing and supervising the work incident to the care and treatment of patients assigned to the general medical division, the general surgical division, the pediatric division, the contagious division, the obstetric and gynecologic division, the psychiatric division, the out-patient department, the operating rooms or the private pavilion; having charge of all equipment and supplies; having charge of all subsidiary workers; having charge of the central supply room; making rounds of inspection; conferring with and advising nurses; conferring with the director of nursing services and with the medical staff; preparing reports and recommendations.

"Minimum Qualifications: All qualifications for the head nurse with advanced study in teaching and ward administration. Education, experience and ability in the specialized clinical field to which she will be assigned. Three or four years of successful nursing experience, one of which shall have been in the capacity of head nurse or instructor. Administrative and teaching ability, tact and good judgment."

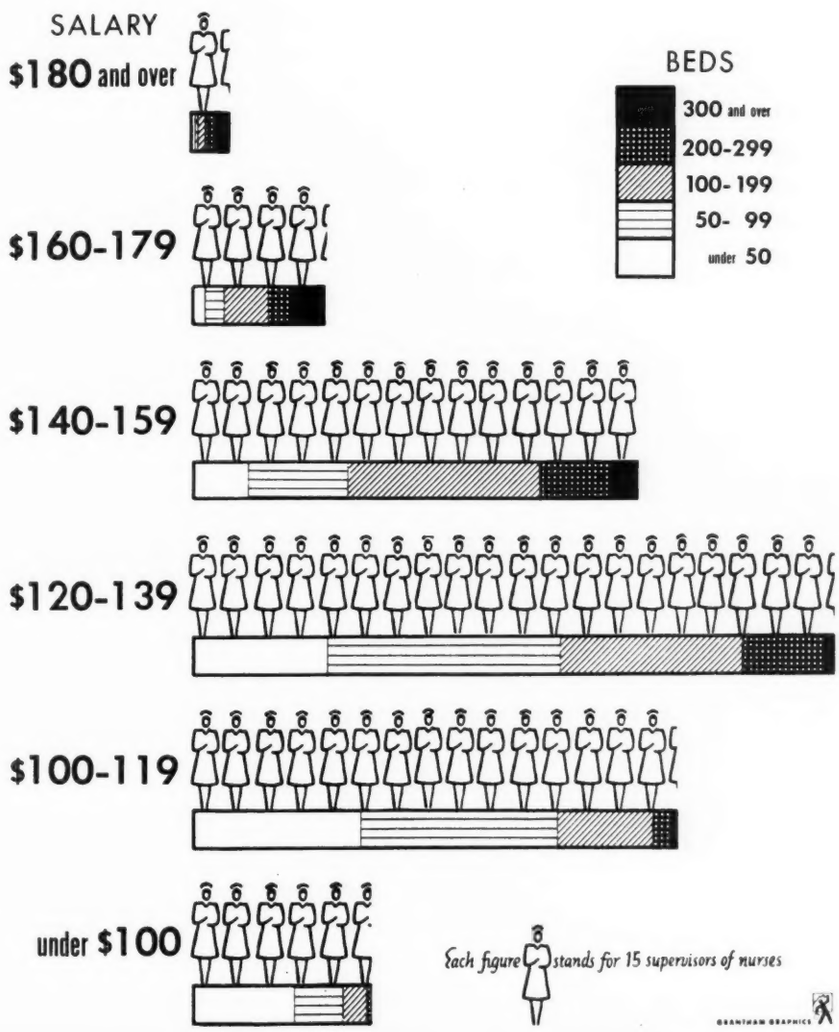
The minimum qualifications of the head nurse are given elsewhere as graduation from an accredited school of nursing; registration and licensure in states in which they are required; knowledge of good hospital nursing practice acquired through special nursing courses or experience; one or two years of graduate experience; specialized knowledge in the particular branch of service to which she will be assigned; interest in teaching, and ability to instruct.

Dr. Malcolm T. MacEachern, among others, has pointed out the important part played by the nursing supervisor in hospital organization. Concerning the supervisor of the operating room, Doctor MacEachern states in "Hospital Organization and Management" that she is a specialist in her specific work. "She may have a large organization under her control and in such case must be possessed of considerable executive ability. On her devolves the responsibility for the maintenance of valuable equipment, of proper preparation of all supplies required, of assigning time for operations in such a manner as to avoid friction with and among the surgeons and of knowing the capabilities of the nurses assigned to her service so as to allocate their work properly."

Average Salaries of Nursing Supervisors, 1940

Area	*Size of Hospital*						
	Under 25	*25-49*	*50-99*	*100-199*	*200-299*	*300-499*	*500 and Over*
Eastern	$125	$124	$127	$141	$146	$157	$190
Southern	112	116	121	129	136	153	162*
Mountain-Pacific	114	119	129	143	138	158	–
Middle West	111	114	122	131	136	166	166
Canada	82**	93	100	113	131**	120*	160*
Total	113	116	123	134	138	157	173

* Only one report received.
**Only two reports received.



The average salary for nursing supervisors is $128 per month.

Success Story

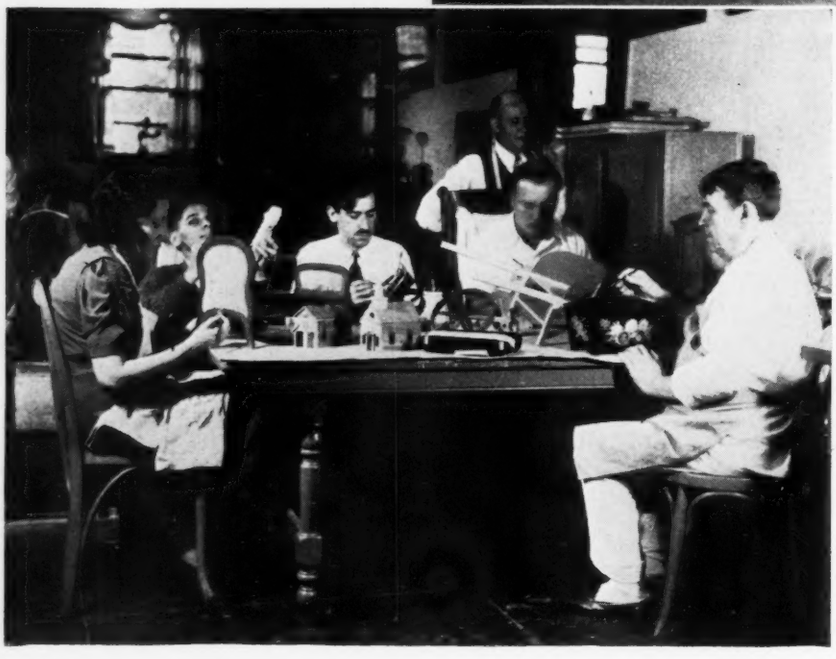
CELIA M. PEARSON and

WORKERS in occupational therapy have come to realize during the past few years that while their field of effort must still include the old objectives, *i.e.* restoration of function in physical maladies and mental normality in psychoses, it must now include a new conception, responsibility to the "whole man," if it is to fulfill its real purpose.

Classes meet under the guidance of expert teachers for the study of current events, story writing and other subjects of interest.

Disabled musicians loosen their stiff, arthritic joints and also increase their latent skill during the hours devoted to practicing their favorite instruments in the music room set aside for them.

Fine ideals of craftsmanship have always distinguished the products made in the workshop of the occupational therapy department.



This changing focus has recently been recognized by Montefiore Hospital for Chronic Diseases, New York City, after studying the effect of psychotherapeutic treatment on many cases that were physical in origin and symptoms. As a consequence, a revised program of activities has been inaugurated in the occupational therapy department that is in marked contrast to its previous focus of interest on the production of fine hand crafts.

At the same time another innovation was made by appointing a salaried part-time medical consultant to act as liaison officer between the medical staff and the occupational

Miss Pearson is in charge of the occupational therapy department and Doctor Stein is consulting physician at Montefiore Hospital, New York.

on Occupational Therapy

IRWIN D. STEIN, M.D.

therapy department. This step added a scientific rationale to occupational therapy, which, it becomes evident, is rapidly asserting its rightful place as an integral part of the field of medicine.

A beginning was made by organizing a nucleus of alert, though disabled, patients in various group activities of a cultural nature. It was felt that this would not only provide a healthy medium of self-assertion but would combine with it the discipline of collective experience. The circular response such projects would evoke might, it was believed, act therapeutically upon individuals and at the same time serve to form a body of public sentiment and experience that would prove a wholesome leaven in the entire patient population.

A census to determine the cultural and intellectual interests of the patients as a whole was the first joint activity assigned the group. The result showed a marked demand for training in music, current history, creative writing and debating. Shortly afterward, classes to meet these requests were begun with the cooperation of the adult education program of the New York board of education. The eager response with which the classes were welcomed showed how appropriate the choice of subjects had been.

Prior to this time there had been a few scattered patients in the hospital who practiced the piano or violin in an odd corner of a workshop. The solitary hours thus spent, however, did not release them from their natural introvert tendencies. Would-be authors sat wrapped in thought, paper and pencil in hand, fearful of displaying to an unappreciative world the brain children they so laboriously produced. Owing to shortage of space, there was no recreation room available in which social intercourse between the wards could be carried on along informal lines. Although the semiweekly moving pictures in the large social hall provided fine diversion, they did not afford opportunity for the give-and-take of open discussion.

Early in the establishment of the new program, therefore, when group needs began to develop, it was necessary to remodel the library to form a classroom and to sacrifice a stockroom to make a music practice room.

In this congenial environment the authors, gathered in group study under a sympathetic teacher, soon lost their sense of isolation, and diffidence was swallowed up in ambition once they found themselves classed as "writers" in all seriousness. Retiring patients became surprisingly vocal and typewriters were at a premium

Left: Crippled patients cheerfully try out a new step. Below: The duplicating machine is useful.

Left: Typewriters are busy as the "deadline" draws near. Right: Editors at work on the magazine.

when the day for new assignments drew near. The production of a literary magazine proved to be one of the most worth-while projects in "mass experience" that had been carried on in the department for a long time.

Classes in music appreciation, harmonica playing and group singing, as well as individual teaching, drew the isolated musicians from their corners. Wheel-chair patients with a hidden urge for dramatic expression were taught the production of radio drama, which when broadcast through the hospital shed a pleasant glory upon their heads.

Perhaps the greatest therapeutic outlet, however, proved to be in the field of art. Many unexpectedly gifted persons were discovered and the joy of using color and form satisfied the creative instinct in so large a proportion of patients that it is now classed as our major interest. At a recent exhibition of students' work at the Metropolitan Museum of Art, New York, sponsored by the Adult Education Division, four of 300 works selected from as many thousand by the authorities of the museum were from Montefiore Hospital.

Satisfactory as these results have been, what may be termed secondary consequences seem even more noteworthy. Before long some of the responsibilities involved with these new privileges began to assert themselves. The adaptation of the library for use as a meeting place soon made logical the placing of 8000 volumes under the care of the occupational department. Interest in literature and books developed and with it a sense of the need for taking care of them and of the library as a whole. Groups became active in marking and cataloging books; the necessity of rebinding and repairing created a new craft project in the work shops.

The small stencil duplicator bought to print the magazine was soon found to be great fun to operate and also useful to the hospital administration in preparing forms and papers. Before long an organized group of patients was kept busy at congenial work printing a large amount of material for the institution.

The phonograph donated for the use of the music appreciation class was found to be available also for gayer use. The younger element, taking advantage of this, began to find stimulation in dancing; badly disabled patients would often try a turn on the floor in an attempt to learn some intriguing new step. Even the doctors were surprised at their activity and lack of self-consciousness.

Eventually, the supervision of the radio service and the movies was placed in the care of the occupational therapy department. This unification of all recreational activities in the hospital created a distinct sense of proprietorship among the patients and advice and offers of help began to pour in. The repair of the radio headphones that are supplied to all the beds in the hospital was assumed by former radio men among the patients, thus relieving the engineering department of an endless job.

In this live group it has been easy for new patients to find a place for themselves. Not easy to convey, but gratifying to see, are a certain unanimity of feeling, a heightening of morale, a group response that weld together in a surprising way the many conflicting elements found in an institution that serves so large a population and is made up of persons of so great a variety of national origins. There has been no interference with the helpful physical work accomplished; many notable results have been achieved as a result of a planned therapeutic program under the direction of the consulting physician.

A matter still to be solved is the need for a scheme of activity that will provide some financial return to skilled but handicapped patients; this is a real psychotherapeutic, as well as an economic, necessity. It is, unfortunately, an unrealized vision of the future!

The benefit to the hospital as a whole of a cheerful esprit de corps among the patients and its relation to successful treatment by the medical staff are not within the scope of this article. However, the sense of organic vitality and the consciousness that real life with its opportunity for growth and development has not slipped entirely away which are being increasingly evidenced among our patients have already justified many times the additional effort that such expansion has brought.

Grading Patients for Surgery

MEYER B. SAKLAD, M.D.

THE classification of a patient as to his ability to withstand surgery is a common practice. The assignment of a grade may be in the form of a number, a letter or, in an attempt to be more explicit, a word, such as "good," "fair," "poor" or "serious."

In any attempt to assay a patient as to operative risk many factors that may have a bearing on the end result must be considered. One must include in his mental calculation not only the patient's physical condition but also such additional factors as the surgical procedure that is contemplated; the ability and skill of the surgeon in handling the procedure; the attention to postoperative care, and the past experience of the anesthetist in similar circumstances. It can readily be seen that the assignment of an operative risk to an individual will depend upon the set of circumstances that prevails at that moment. It can also be seen that a given patient may vary as to his operative risk depending upon the type of surgery to be performed.

The attempt to determine the operative risk may be of value in prognosis but grading patients in this manner is useless from a statistical point of view. It is useless for several reasons: the excessive number of variables to be considered, the tremendous degree of variation in different clinics and under different hands and the complete lack of agreement as to definition of terms.

It was felt that for the purposes of the anesthesia record and for any future evaluation of anesthetic agents or surgical procedures, it would be best to classify and to grade the patient in relation to his physical state only.

In classifying the patient as to his physical state fewer variables need to be considered, and with the smaller number of factors a more nearly common definition will result.

Doctor Saklad is director of anesthesia, Rhode Island Hospital, Providence.

If the statistical system recently devised by a committee of the American Society of Anesthetists is employed it will be possible to correlate the relationship between end result, the operative procedure and the patient's preoperative condition. It is this preoperative condition that we term the physical state.

Since the system was devised with the hope that qualified anesthetists in different parts of the country would employ this method of collecting statistics and since it was desired to employ a common terminology, the various degrees of physical state were carefully defined in a booklet drawn up by the society for this purpose. The six degrees of physical state and their definitions as they appear in this booklet are as follows.

Degrees of Physical State

1. An individual who has no organic disease or in whom the disease is localized and does not cause any systemic disturbance or abnormality.

This category includes patients suffering with fractures, unless there is shock, blood loss, emboli or systemic signs; congenital deformities, unless they are causing systemic disturbance; localized infections that do not cause fever or other illness; certain orthopedic deformities, and uncomplicated hernias. Any type of operation may fall into this class.

2. An individual who has a moderate but definite systemic disturbance that is caused by the condition that is to be treated by surgical intervention or that is caused by other existing disease.

Examples of this classification include mild diabetes; mild acidosis; moderate anemia; septic or acute pharyngitis; chronic sinusitis with postnasal discharge; acute sinusitis; mild thyroid toxicosis; acute osteomyelitis (early), and chronic osteomyelitis.

3. An individual with severe systemic disturbance from any cause or causes. It is not possible to state an absolute measure of severity as this is a matter of clinical judgment.

The following examples are given as suggestions to help demonstrate the difference between this class and No. 2: complicated or severe diabetes; combinations of diseases that severely impair normal functions; complete intestinal obstruction that has existed long enough to cause serious physiologic disturbance; pulmonary tuberculosis which, because of the extent of the lesion or treatment, has reduced pulmonary vital capacity sufficiently to cause tachycardia or dyspnea; severe trauma from accident, and lung abscess.

4. Individuals with extreme systemic disorders that have already become an imminent threat to life regardless of the type of treatment. This class is intended to include only cases that are in extremely poor physical status. There may not be much occasion to use this classification but it should serve a purpose in separating the patient in poor condition from others.

Some examples are severe trauma with irreparable damage; complete intestinal obstruction of long duration in a patient who is already debilitated, and a combination of cardio-vascular-renal disease with marked renal impairment.

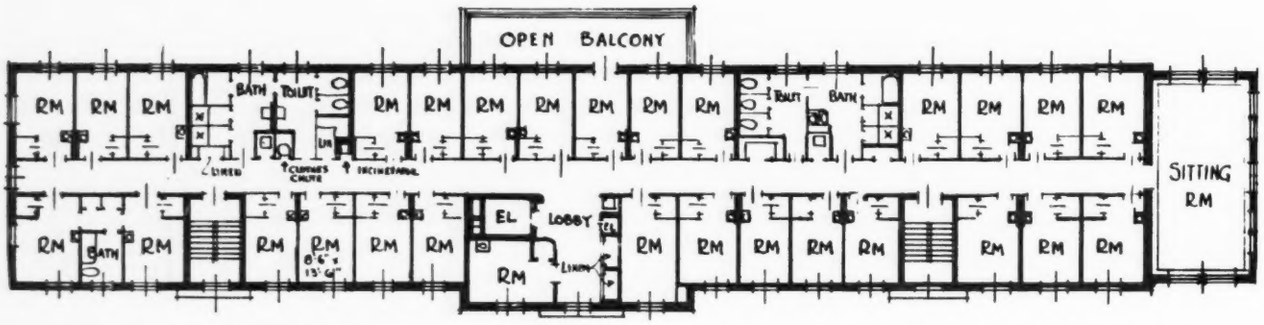
5. All patients who are operated upon as emergencies who would otherwise be in classes 1 or 2.

6. All cases that are done as emergencies who would otherwise be in classes 3 or 4.

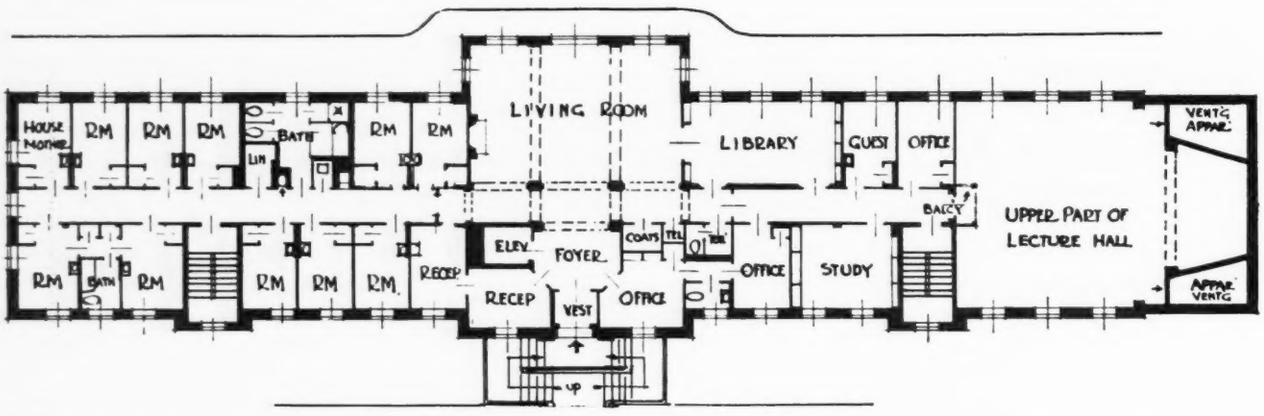
An emergency operation is arbitrarily defined as a surgical procedure which, in the surgeon's opinion, should be performed without delay.

It may be difficult, at first, for the anesthetist to classify patients as to their physical state only. Subconsciously, he is likely to allow his knowledge of the contemplated surgical procedure to influence him in his grading of patients. But with care, diligence and attention to detail he will soon limit himself to the consideration of the patient's condition in his classification.

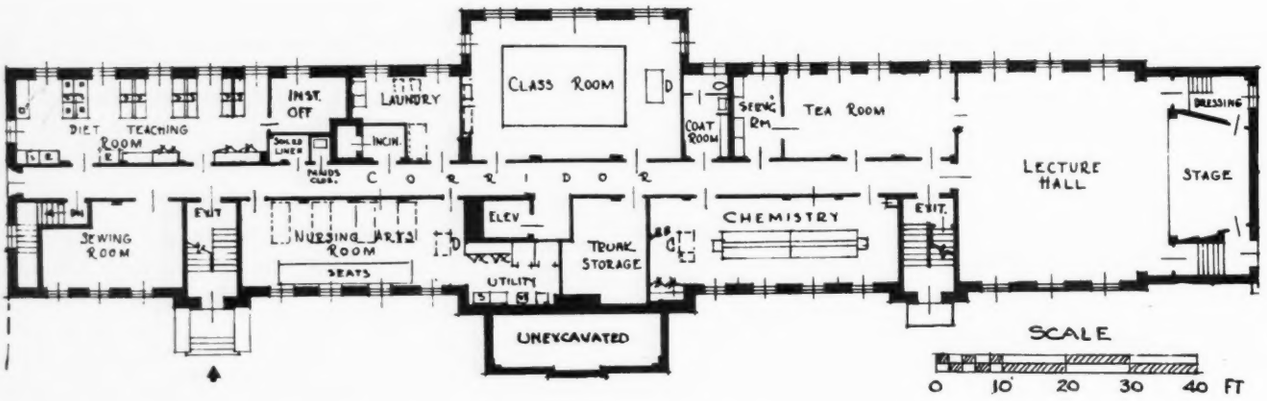
Nurses at St. John's Hospital



The second, third and fourth floors are given over to single rooms for the students and suites for the nursing supervisors. Each of the single rooms is 8½ by 13½ feet and is large enough to afford flexibility in the arrrangement of furniture. At the eastern end of each floor is a sitting room that extends the width of the building. A balcony overlooks the river.



The main entrance of the residence leads into a large living room overlooking the Merrimack River. Adjacent to this room are the library, reading and reception rooms. The first floor also contains the balcony of the lecture hall, in which space has been provided for motion picture apparatus and sleeping rooms for the supervisors and the house mother.



The ground floor is devoted primarily to teaching. Space has been allotted for a classroom, with a seating capacity of 50; a diet teaching room; a nursing arts room, and a large lecture hall two stories high, which will be used both for the instruction of the students and for social activities. Stevens, Curtin, Mason and Riley of Boston are the architects.

Will Have "Space for Living"

WILLIAM A. RILEY

Stevens, Curtin, Mason and Riley, Boston.

IN recent years many hospitals have found it expedient to provide living accommodations for their nursing personnel in adequate, modern fireproof buildings. The housing of nurses in old buildings without facilities for proper living and social activities not only is impracticable but also usually makes it impossible to conduct a school of nursing on any really sound educational basis.

In June of this year, St. John's Hospital, Lowell, Mass., commenced building operations for a 100 bed nurses' residence situated on the banks of the Merrimack River overlooking Centralville Heights.

The approach and development of these plans were given considerable thought and study. Sketches were made that incorporated the advantages of available site, orientation, prevailing winds, local and state codes and a survey of requirements for a school of nursing. A limited budget necessitated the choice of construction materials that would be economical and would keep maintenance costs to a minimum.

The accompanying plans and perspective show the general arrangement and systematized planning. There are five floors with all teaching and recreational rooms situated on the ground and first floors; the three upper stories are assigned to living quarters.

A splendid location was available with ample light and air on all sides. Sufficient land was purchased to afford future extensions, parking space and tennis courts. The residence will be connected with the hospital building by a tunnel.

The building is constructed of red brick with white limestone trimmings. The design is of modern character of which simplicity is the keynote. The main entrance steps are of local gray granite with wrought iron balustrades; these form a base for the limestone entrance. Symmetrical grouping of 30 nurses' rooms on each floor made it possible to have the main entrance in the center, with exit stairs near the ends.

The natural grade of the lot permitted the basement floor to be at grade, thus allowing high windows that provide ample daylight, which is essential for teaching purposes. A pipe space below the ground floor makes it feasible to eliminate all piping from the teaching floor and to provide service rooms for elevator and electric equipment.

The entire ground floor is devoted to the teaching function of the building. Three large teaching and demonstration rooms are planned so that 16 students may receive instruction in diets, chemistry and nursing arts. In the nursing art room cubicles are provided so that the students may undress when taking the rôle of patients. Space is also provided for students' chairs for classroom work.

Architects' drawing of the attractive building of red brick with its white limestone trimming.

A large classroom with a seating capacity of 50 is situated near the demonstration rooms.

On the same floor is a lecture hall. Here the entire student body can meet for both instruction and social activities. A stage, 12 by 18 feet, with two dressing rooms is located opposite the entrance. Close by is a serving room in which food will be prepared both for the tea room and for any social functions that are held in the lecture hall. The hall was made two stories high in order to provide adequate lighting, proper acoustics and space for motion picture projection apparatus at the second floor balcony level.

First Floor Planned for Recreation

The first floor will be used chiefly for recreation and sleeping rooms for supervisors. The main entrance leads directly to a 26 by 34 foot living room overlooking the river. Adjacent to this focal point of interest are the library, reading and reception rooms. Offices for the superintendent of nurses and instructors take up the rest of the space.

The living room contains some 900 square feet of space. The architectural treatment is of modern design. In one end of the room is a large fireplace in black and gold marble with a large mirror directly over it. On the axis of the fireplace is the main entrance to the library. Here in this room, called the "Seton Library," one may retire for reading and rest.

Both the living room and library are treated in figured gumwood; and in the library the paneling extends from the base to the curved ceiling, which is acoustically treated.

On the left of the library is an office for the instructor and adjacent to it is a room for guests. On the opposite side of the corridor is the study and reading room. A short distance from these rooms is the balcony, which affords a splendid view of the lecture hall.

On the second, third and fourth floors are single rooms for the students and suites for the superiors, with a large sitting room that extends the entire width of the building on each floor. The two story living room extension made it possible to include an open air balcony.

A glance at the plan of the typical sleeping room will show that considerable study was given to this unit. Each room is 8½ by 13½ feet, a size slightly larger than is found in most residences. The width of the room affords flexibility in the arrangement of the furniture. Each room will have its own lavatory and built-in medicine cabinet, towel bar, large closet with two shelves and several electric outlets and switches. The floors are of black and gold terrazzo with a 6 inch flush paved terrazzo base. This feature, although high in initial cost, offers a real economy in maintenance.

Door frames are of steel without molds. The color scheme is ivory to harmonize with the maple furniture. All windows are of the reversible type, that is, fitted with patented hardware to permit cleaning from the interior of building.

Each room has a light bracket and outlet at the medicine cabinet and two wall duplex outlets suitably located for future use. A nurses' call system with buzzer is provided by which a nurse can be called from the first floor office. Radiators are of the hospital type, set in recesses to permit maximum floor space. All hardware throughout, except in the wood paneled areas, is of satin finish chromium.

A summary of building characteristics and costs may be of interest to those who are contemplating better housing facilities for their nursing personnel.

Overall size of the building is 195 feet long, 34 feet, 10 inches wide and 55 feet high from floor of pipe space to roof.

The building is of noncombustible material with steel framing and steel bar-joist with 2 inch concrete slabs for the floor construction.

Approximate figured size is 355,000 cubic feet and the total cost of construction, exclusive of fees and equipment, is $226,000, or 63 cents per cubic foot. The cost per bed is approximately $2260 and the total cubic feet of space per nurse is approximately 3550.

There is a total of 100 individual sleeping rooms which, together with rooms for teaching, recreation and offices, makes a total of 150 rooms. Large rooms, extensive use of terrazzo floors and paved bases, deep concrete caissons required to reach the original bank of the river, parking area, laundry dryer, elevator, incinerator, clothes chute, modern lighting, ventilation and fixed equipment, all will have a direct bearing on the total cost as well as on the cost per cubic foot.

It is anticipated that this new residence will be a more practical unit of the entire institution than the old, and a more economical department to maintain.

Psychiatry for Nurses

Florida's second annual Psychiatric and Mental Hygiene Institute for Graduate Nurses was conducted this year at the Florida State Hospital at Chattahoochee, Fla. It offered a two day program of theoretical instruction and practical demonstrations.

Some 50 graduate nurses representing a cross-section of the profession in private, hospital and public nursing were registered for the institute and accommodated at the state hospital's nurses' home for the two days. Students of psychology from the state university and the state college for women, together with students from the hospital's school of nursing, attended a number of the daytime sessions.

The institute opened with an address of welcome by the superintendent of the hospital. The chief physician briefly explained the purpose of a mental hospital. Members of the resident and consulting staffs spoke on the following topics: diagnosing mental disease; the use of insulin and metrazol in treating schizophrenia; surgery for mental patients; malaria therapy; manic depressive psychoses; dementia praecox; epilepsy; the problem of hereditary tendencies, and occupational therapy.

The broad aspects of mental hygiene and their relation to social and economic problems were recognized in planning the program. An official of the social security board addressed the group on the operation of the Social Security Act in Florida and the attorney-general of Florida spoke informally at a dinner given by the hospital.—J. H. Therrell, M.D., *superintendent, Florida State Hospital, Chattahoochee, Fla.*

"Trouble Shooter" Is an Asset

to Hospital Public Relations

HAROLD A. SMITH

SIX years ago the administrator of University Hospitals, Iowa City, Iowa, felt the need for personal contact between the hospital and its clientele out in the state. He, therefore, appointed a field representative, or director of public relations. This work was true pioneering because, as far as can be learned, no other state hospital has a full-time worker in the field.

The field representative leaves Iowa City on Monday noon and goes to a county seat (there are 99 counties in the state) where contact is made with the county officers—judge, clerk, auditor, board of supervisors and the director of relief—who are vitally connected with the commitment of indigent or state patients to University Hospitals. Contact is also made with each doctor in that county (3146 doctors in the state) to answer any question he may have concerning the commitment of patients and to give him correct information concerning hospitalization.

Visits are made to every hospital in the county, as well as to all state institutions, since these may send patients to University Hospitals.

Inasmuch as all state institutions are supported from appropriations made by the legislature, the president of the university suggested that whenever possible the state senators and representatives be extended a courtesy call to inform them of the work being done in the university, the college of medicine and University Hospitals.

Talks are given to service clubs (Rotary, Lions, Kiwanis), chambers of commerce, medical staffs, nurses, women's clubs and other interested groups.

The work is interesting and challenging because new problems arise every day. The duties of the field representative are manifold. He must be a bearer of good will, a disseminator of accurate information. He must receive complaints and criticism, listen to the problems and endeavor to find solutions for them, convey greetings and special announcements to the doctors of the counties from the dean and the faculty of the college of medicine. During each interview he must listen carefully, making notes for the weekly report on that particular county. All correspondence must be carried on with the dean or administrator so that the field representative does not obligate himself in any way or usurp the authority of his superiors.

He returns to Iowa City on Friday night, often having gone more than a thousand miles during the week. Saturday and Monday forenoons are spent in dictating a report on each interview held in the county. The president, dean, administrator and others concerned with this work each receive a copy. Inquiry sheets are compiled for the president, the dean, the administrator and any head of service to whom an inquiry should be sent.

Every Saturday at 11 o'clock the field representative has an interview with the dean and every Monday at 11 with the administrator. At this time he gives a brief résumé of his experiences in the county and discusses plans for the next week's work.

Hospitals are in business for the public's health and, like every business organization, they must keep abreast of the needs and wishes of their particular public. This article tells how one institution keeps in touch with the "clients" through its field representative

Every three weeks the president interviews the field representative. Reports are made to the dean on all new ideas, suggestions, criticisms and comments from the doctors and to the administrator regarding contacts with the county officers, as well as complaints about service, patients or delayed reports to the doctors and other administrative matters. The representative is given a carbon copy of each letter sent from the office of the administrator in reply to the inquiry brought in. In this way he gains much valuable information and is able to answer this question the next time it is asked.

The college of medicine with its great clinical laboratory, the University Hospitals, is a teaching institution of recognized standing. There are 308 students in the college of medicine, 46 professors, 63 lecturers and assistants, 19 department heads, 23 junior interns, 33 assistant residents, 170 graduate nurses and 200 nurses in training. In addition, the necessary staff of technicians, anesthetists and other personnel usual to the modern hospital is employed. There are 700 beds in the general hospital and 200 in the children's hospital.

The University Hospitals treated 14,000 indigent or state patients during the past year. Each county is apportioned a certain percentage of this number, based on population. Since the hospital is primarily a teaching institution, these cases afford excellent clinical facilities for the college of medicine. No county pays directly for hospitalization at the University Hospitals as this comes from the general tax funds of the state.

Another unique phase of this service is the ambulance system, the only one of its kind in existence. A fleet of 20 ambulances brings these patients from every part of the state and returns them to their homes. The Uni-

Mr. Smith is field representative of University Hospitals, Iowa City, Iowa.

versity Hospitals is able to transport patients at approximately 1½ cents per mile per patient. This makes a huge saving to the state each year as against 5 cents a mile, the fee that would be paid to other ambulances to transport them. Most of the ambulances in the hospitals' service pass the 300,000 mile mark before they are traded in for new models.

Much valuable information is gathered by these contacts throughout the state. Policies have been changed because of the information brought in and much misinformation and misunderstanding have been corrected, for doctors are willing to tell the field representative, and often in no uncertain terms, just how they feel about certain policies.

As the dean stated some days ago: "After six years we feel this work is a vital part of our organization and will be permanent." The administration is sincere in its desire to receive constructive criticism of the institution.

This, then, is the business of the "trouble shooter" for the University Hospitals at Iowa City.

House Officers for Small Hospitals

Excerpt from the report of the Commission on Graduate Medical Education

THE question is frequently asked: What provision should be made for internships and residencies in that large group of hospitals with an average daily census of less than 100 patients? There is no one answer to this question. Some of these institutions now offer internships and residencies while most of them have made no provision for such training. Although some of these hospitals now offer excellent internships, most of them cannot develop educational programs that will meet the new requirements for satisfactory internship or residency. Nevertheless, they need the type of service that interns and residents now give.

In many hospitals internships and residencies have been developed not because of demand for such openings by medical students, but rather because the hospital and its staff have realized that the presence of interns or residents in the institution results in a higher standard of patient care and makes it possible for the staff physician to transfer to the intern or resident many of the routine duties required by modern scientific standards. These are tasks that he does not wish to delegate to a nurse and yet he does not wish to perform them himself because they are time-consuming and his time is needed elsewhere.

As more hospitals realize the value of intern and resident service, they would make places for interns and residents if this could be done without shouldering the obligations of developing educational programs and if they could find men to fill the openings. There are about 25 per cent more openings each year among the internships on the approved list of the council on medical education and hospitals of the American Medical Association than there are graduates of medical schools in this country. Actually, the shortage is greater than this. Many of these smaller hospitals, partly because they cannot find men to fill their openings and partly because they do not fully realize the number of men needed to provide adequate patient care, do not offer a sufficient number of internships or residencies to staff their hospitals properly from the standpoint of either the institution or the student.

It is suggested that these smaller hospitals meet the dual problem of improving patient care and of relieving the medical staff of many time-consuming tasks by employing salaried house officers. Such positions should be available to young graduates who have completed an internship but who want more experience before entering general practice.

There should be a distinct understanding that these physicians are not serving as residents. They should not expect any organized teaching from the staff and, after leaving the hospital, should not expect to be qualified thereby for one of the specialties. They would be serving simply as paid medical assistants living in the hospital and would be expected to assist the staff and to carry out the many routine duties delegated to them in return for which they should receive a salary commensurate with the value of the services they render to the hospital.

The employment of house officers would not add as much to hospital expenses as might be anticipated at first blush. Many hospitals now find it necessary to employ graduate nurses or trained technicians to do the tasks that a young physician could perform more expeditiously. In addition, it is believed that one well-trained physician acting as a house officer, because of his training and familiarity with procedure, can normally perform most of the work of two interns. In order to avoid confusion in terms, these young physicians should be called "salaried house officers," not residents. Such appointment should be on a year-to-year basis and a physician may spend as many years in this type of work as he wishes. The experience will make him much more competent to enter general practice.

Some physicians in general practice believe that these salaried house officers will settle in the local community and become a threat to their own practice. On the other hand, the service of house officers in the hospital will acquaint the staff with physicians who may settle in the community if there are openings available. Such early acquaintance can well react to the mutual benefit and satisfaction of the younger and the older physicians. When adequate salary is available, there should be no shortage of young men who are willing to become salaried house officers.

Southampton Believes in Budgets

RAYMOND P. SLOAN

"WHAT a wonderful place to be sick in." The visitor to the old village of Southampton on Long Island, N. Y., breathed deeply the salt air blowing fresh from the sea. Down Meeting House Lane he walked, curiously inspecting the group of buildings on his right that nestle inconspicuously amidst trees and green lawn. As he rounded the corner, there emerged more boldly into view, the low, modern brick building known as Southampton Hospital.

"What a wonderful spot in which to recover," he added, as he walked up the path and entered the white doorway.

Other visitors to Southampton, and there are countless of them during each summer season, have said the same. Some are merely passers-by, sightseers who remark at the wonderful exposure of windows that face the sea in one direction and that in another look out upon the attractive homes of summer residents. Others, visitors to the hospital, exclaim at the peace and quiet and cleanliness of it all. There are those, too, residents of New York City, lying 100 miles to the west, who deliberately postpone medical or surgical attention until summer when they can take advantage of the hospitality and modern facilities of their own community hospital.

This has been going on since 1909, not quite in the same manner to be sure, but that year is significant in the town's history because it marks the organization of the Southampton Hospital Association whose object was and is, "the establishment, support and management of an institution for the purpose of affording medical and surgical aid and nursing to sick or disabled persons of every creed, nationality and color."

The little building designated as Southampton Hospital had but 25 beds in those days. These soon proved inadequate and, four years later, an addition was erected that brought the capacity up to 50 beds. The demand for service continued, however, until in 1929 the interest and support of many friends made further expansion possible, bringing the bed capacity to 100, with 20 bassinets. The years have brought, too, a nurses' residence, which also houses the training school, and, as recently as 1932, a south and north wing to the main hospital in which operating and delivery rooms, the x-ray department and dispensary are housed.

Older residents of the village have watched the steady growth of the hospital with wonder and pride. Summer residents have adopted it as their own, worked for it and supported it and the occasional visitor to the resort during the last thirty or more years has witnessed the introduction of modern medical science into a 50 mile area on the end of this long peninsula stretching into the Atlantic Ocean.

Much of this accomplishment would not have been possible without the aid of those physicians who have made Southampton their summer home. Today the medical service is provided by an attending staff of 36 with a consulting staff of 25. The medical board is headed by Dr. Joseph S. Wheelwright, who has been active in the development of the institution through its years of steady growth. Resident service or its equivalent is rendered by three of the younger men on the attending staff who alternate in serving one month at a time, during which period they are on call day and night.

All this has been done for the hospital by its enthusiastic friends, as we have discovered. In years past the great houses of the neighborhood

were thrown open to bazaars and fetes for its benefit. Not only the landowners but their wealthy and socially prominent guests, impressed by the stories of valorous work done by the little institution during storm, shipwreck and epidemic, paid homage by bestowing generous gifts upon it. That interest continues but with changed economic conditions the hospital must now in a large measure finance itself.

How is this accomplished? The chief source of revenue is from private rooms, which cost anywhere from $6 to $20 a day. There is always a demand for higher priced accommodations owing to the presence on the staff of many prominent New York surgeons who have homes in the neighborhood and use the hospital as their summer workshop. Semiprivate rooms are available at $5 and $6, while the ward rate is $3.50. It is evident that the hospital must derive sufficient income from service rendered during the summer to keep it going during the leaner winter season.

In addition to revenue from patients, about $8000 is received from welfare funds. Then there is a hospital drive each year, which brings in anywhere from $4000 to $15,000. Looking at another page of the ledger we find that free work totals about $25,000 a year. There must be careful planning if the hospital is to be self-sustaining.

A few minutes spent in the office of Ellen Jacobsen, the superintendent, inspecting the budget which she keeps for herself and her staff tells the story. Every head nurse, every department head knows exactly how much she has to spend for the entire year and for each month. Miss Jacobsen works it out carefully as of January 1 for the ensuing twelve months, making allowance for varying conditions and price trends. The figures are studied carefully at a staff meeting every month, each individual having to answer if she reports in the red.

A most effective way to control waste! Administrator and department heads alike will vouch for it. It develops a spirit of competition and pride among the various departments to keep within the budget, and it is not at all unusual to have a ward maid or some other worker make suggestions for possible economies. It keeps every member of the staff on his toes.

Looking over a few of the figures for 1939 we find that drugs, for example, went over the budget by $24.81, as did upkeep and repairs, which were $40.11 in the red. Sterile supplies, on the other hand, came out $10 below and surgical supplies, $9 below. The budget for one ward was $878. That particular ward, for certain good reasons, reported expenses of $903, just $25 over. For the year 1939, the administrative budget was exactly $500 in the red.

There is also a nursing budget which covers salaries, textbooks, new equipment for the training school, graduation, traveling expenses, advertising, printing and stationery, doctors' lectures, traveling expenses for affiliating nurses and miscellaneous items.

It's all there, showing the comparative figures for several years past. As these studies accumulate it becomes easier to establish budgetary figures that are more nearly accurate. Think of the advantage to the administrator of having before her at all times a true picture of hospital operation! One ward is in the red for, let's say,

The nurses at Southampton Hospital have a delightful residence. The home also houses the training school for 40 student nurses. In addition to the students, there are 13 graduate nurses, 10 of whom are local girls.

the month of June. The answer is simple. The head nurse is away and her assistant is apparently not evincing the same interest. That is something to think about. On the other hand, the same department under the same conditions may show a considerable saving from the budget figure. Anxious to make good, that assistant may have discovered economies that her superior officer overlooked. An equally significant situation!

Budgeting unquestionably helps to run the hospital economically and efficiently. There is also the help that a large and loyal auxiliary contributes during the year. Ten women's groups located in the different towns throughout the area served by the hospital have a total membership of 75. In addition, many other women in Southampton work indirectly for the hospital, rendering valiant service to it.

Above: A cheerful, homelike atmosphere pervades private rooms.

One auxiliary group contributes $1200 for the support of a bed; another turns over $1800 to the hospital for some special need. Others, individually and collectively, mend linen, cover quilts, make curtains and donate some 2000 jars of preserves during the year. It is not an unusual sight when the Long Island potato crop is at its height to see the hospital truck picking up great bags of spuds fresh from the fields and hauling them back for safe storage. Thanks to its auxiliary friends the hospital receives between 200 and 400 bushels each season.

The work of these women's groups receives the recognition it justly deserves from the governing board of the institution. Four times a year they meet with members of the executive committee at which time they are requested to submit suggestions about the hospital's work, present any criticisms they may have heard about its services and receive the appreciative thanks of the trustees.

This tie-up between the auxiliary and the board is significant, indicating the increasingly important part that women are playing in hospital work today. Women also serve on the hospital board. There are 11 of them, in fact. One, also, is a member of the executive committee of seven. The executive committee meets once each month and the directors, four times a year. The directors, however, are invited to attend executive committee meetings if they desire, thus tying them in more closely with the hospital work.

Both the board and the executive committee are divided between men and women who reside permanently in Southampton and others who make it their summer residence only. Three out of the seven members of the executive committee are year round residents and a third of those who serve as directors live permanently in the town. This ensures community interest and support.

While on the subject of community interest, it became apparent during the years that the hospital's many services should be interpreted for the benefit of the entire area. To accomplish this, the cooperation of the press in the various towns was solicited in running a series of articles describing the work of each department, interspersed with numer-

Below: The nursery. Bassinets are separated by glass partitions.

ous human interest stories to assure consecutive reading. In this way the steady progress the institution has made has been brought to the attention of all.

More recently, the assistance of the press was invoked to help curtail visiting hours. The following newspaper article tells the story.

Public Cooperation Sought

"After long deliberation, the officers, medical board and superintendent of the Southampton Hospital have decided upon a step that will without doubt increase the hospital's efficiency, protect the patients and bring them back to health in a shorter time. Beginning June 1, visiting hours at the hospital will be curtailed. Visiting hours in the wards have always been from 2 to 4 in the afternoon and from 7 to 8 in the evening every day.

"That is not good for the patient. The doctors have felt this for years. About two years ago the hospital made a rule that only two visitors might see one bed patient at a time; even that mild rule has sometimes met with opposition.

"Then there is the question of child visitors. Children are so likely to be coming down with whooping cough, measles, chickenpox and the other difficulties that beset their age that they should not be brought into a hospital unnecessarily. From now on, no child visitors will be allowed in the obstetrical department of the hospital and no visitors whatever will be allowed there during the time the baby is nursed. One reason for this is impetigo, a skin infection that is sweeping the country. It is easily carried by contact and is not necessarily banished by washing the hands.

"When the general public takes sober thought of the necessity for making rules about visitors at the hospital, the doctors and nurses are sure that the move will be welcomed. The hospital authorities wish to bring the matter before the public so that visits can be planned accordingly and nobody will be disappointed. The new hours for ward visiting will be from 2 to 4 o'clock on Tuesday, Thursday and Sunday afternoons and every evening from 7 to 8 o'clock. In the children's ward the only visitors allowed will be parents; they may come from 2 to 4 on Tuesdays, Thursdays and Sundays, but not at all in the evening because sick children should be put to bed immediately after supper."

Should an institution the size of Southampton Hospital maintain a training school? Those responsible for its conduct reply in the affirmative insofar as it applies to their own work and their community. "You can give better service to your patient," they will tell you. "How else, indeed, can the nursing needs of that part of Long Island be met!"

The existence of the training school reduces the turnover in the graduate staff. Ten out of the 13 graduates are local girls who are used to living in the country and do not mind the long winters. It would undoubtedly be cheaper to conduct the nursing service with graduates exclusively but it would be at a sacrifice to the service as well as to the general health of the community. "But," the officials add, "a training school should not be attempted unless the hospital is able to meet the expenses involved and to conduct a Class A school."

This is precisely what Southampton does in the school it organized in 1924. Not only does it pay good salaries to get the right kind of instructors but it also pays all its doctors for lectures. In addition to the principal of the school, there are two instructors, one of whom teaches theory and the other, nursing art.

Forty Nursing Students

Thoroughly modern facilities, including classrooms and demonstration rooms, are located in the nurses' residence. Approximately 40 girls are in training, some of them from the immediate c o m m u n i t y and others from sections more remote. There is one class each year, numbering between 12 and 15. Each student receives personal attention and every case that enters is available to all for study and discussion. It is also possible to maintain closer supervision over the individual than in a larger hospital. Two scholarships of $450 each are given annually and there are also three scholastic prizes of $100 each and a student loan fund. The work of the graduate staff and students is supplemented by a large number of "specials." During the summer months when the private rooms are filled many patients have their own nurses. This means, too, that such patients must be catered to in other ways. It has been found, however, that they are not as difficult to satisfy in their food and other services as others who have less but aspire to more.

The hospital employs a registered dietitian who visits each patient when he first enters the hospital to ascertain his tastes and preferences. Those on special diets are visited daily. It has been discovered that the presence of a garden, where from his bed the patient can see all manner of green things growing, has an excellent psychological effect. He is less likely to criticize and find fault when he realizes that he is being served vegetables and fruits fresh from the farm. Incidentally, it has also been the experience at Southampton that a farm actually saves money.

Ready for Emergencies

Despite the fact that bed occupancy at Southampton fluctuates from a low of possibly 40 patients at certain seasons to a peak load of 70 at others, the personnel must be maintained constantly for any emergency, and emergencies there are—always.

Southampton still recalls that night in the fall of 1938 when a wind of hurricane force cast great tidal waves upon the land, bringing destruction and devastation to the little village by the sea. Without telephone, without electricity, even threatened with a dearth of water, the hospital staff worked night and day to help those in distress. A dynamo operated from a fire truck cast light in the operating room where one operation after another took place all through the night. Water had to be hauled by barrel. The world outside was completely cut off. Yet in a small world of its own the hospital carried on. "It served to show how lucky we are to have all this modern equipment to work with today," they say at the hospital, recalling that terrible night.

It served to show the community, too, what it means to have its own modern hospital.

In Favor of Floor Secretaries

ABRAHAM OSEROFF

"WILL you take a message for Mrs. Smith, a patient on the third floor?" inquired an anxious voice calling the Montefiore Hospital in Pittsburgh.

A neatly dressed young woman on duty on the floor designated answered in the affirmative. The call had been directed to her by the hospital telephone operator at the main switchboard.

Many other calls had been similarly directed to the third floor, as well as to the other patients' floors, during the day. All calls had been answered with dispatch and at no loss of time to the nurses on the floor.

A "floor secretary" was on duty.

This is a new term that has been added to the vocabulary of those at the Montefiore Hospital. A floor secretary is a person delegated to take care of the many details of a secretarial nature that formerly made demands upon the limited time of the nurses.

When the suggestion was first advanced that it would be advantageous to have floor secretaries, it was received with skepticism; however, it was decided to give the idea a trial.

From the outset the plan proved its worth. Countless calls asking for the condition of patients, requests for diversified information, delivery of flowers, messages to patients and physicians, all of which heretofore had not only taken the time of nurses but also seriously interfered with their nursing activities, were no longer a source of concern.

Better nursing was the immediate result. Instead of frequent interruptions, nurses on duty were able to devote all of their time and attention to their patients.

The extent to which a floor secretary can relieve nurses on duty of details that have no connection whatsoever with nursing can best be determined by observing one of these secretaries at work.

Mr. Oseroff is director of Montefiore Hospital, Pittsburgh.

Record of a Secretary's Day

Time	*Activities*
8 a.m.	Charting temperatures Mothers' charts Check rooms (Door cards for new patients)
8:10	Answer telephone
8:20	Answer telephone
8:25	Answer telephone
8:45	Charts arranged in order for discharge
9:00	Patients' diets checked with kitchen
9:05	Answer telephone
9:06	Answer telephone
9:15	Delivery room charge to bookkeeper
9:30	Distribution of mail
9:45	Telephone call
10:00	Charting babies' weights and temperatures
10:30	Laboratory work (Requests for coagulation time on babies)
10:45	Check charts for doctors' orders
11:00	Telephone calls
11:15	Chart room temperatures
11:40	Doctors' orders; telephone calls
11:45	Lunch
12:15	Telephone calls; also packages checked in and delivered
12:30	Birth certificates written and mailed
1 p.m.	Several telephone calls
1:05	Outgoing telephone calls for patients
1:15	Telephone call
1:20	Compiling charts ready for new admissions
1:45	Telephone call
2:05	Telephone call
2:25	Check doctors' orders on charts
2:35	Schedule circumcision
2:40	Rule time sheet temperature book and daily weight chart for babies
3:00	Afternoon mail
3:15	Afternoon temperature charting
3:30	Flowers, fruit, candy checked in and delivered to patients
3:45	Telephone calls
4:00	Discharged mother and twin girls
4:10	Telephoned social service and made arrangements for public health nurse to visit patient
4:15	Telephone call

While the many activities that take up the time of a secretary are not of such a nature that they should demand any time of a nurse, nevertheless, they cannot be disregarded and must be done by someone.

Answering a telephone call may seem to be a trivial operation to a person seated at an office desk. Such a mere detail, however, becomes a source not only of aggravation but of concern to a nurse on duty who finds it necessary to suspend her nursing activities in order to take a routine message. Multiply this manyfold and it can be seen how extensive these interruptions become and what a strain they are on the vitality and strength as well as on the disposition of the nurse.

Yet the taking of telephone calls and handling similar details are important in themselves. Relatives and friends who call expect to get a report of the condition of a patient, as well as answers to any other questions that may be asked. They expect to be given this information courteously and not to be snapped off rudely. All the floor secretaries at the Montefiore Hospital have had secretarial and clerical training. Proper handling of such calls means building good will for the hospital.

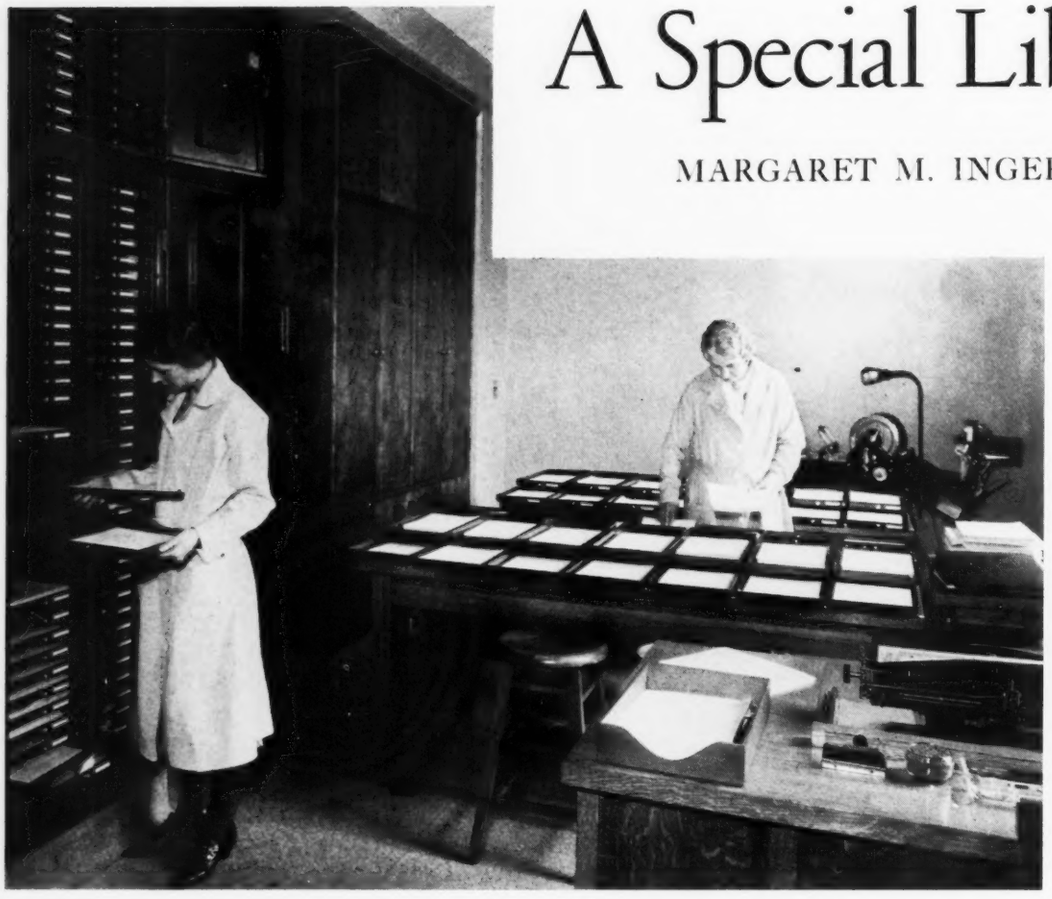
The idea that led to the inauguration of floor secretaries was born of necessity. When the economic depression started, there was a surplus of nurses. Hospitals and nursing schools taking cognizance of the oversupply followed the immutable laws of supply and demand and reduced the size of enrollment classes. In turn, the number of graduates was cut. As the shortage of graduate nurses began to make itself felt, it was obvious that anything that would increase the efficiency of those already available would be most desirable. However, nurses on duty in hospitals already were working to the utmost of their physical endurance.

The question of increased efficiency, which so frequently arises when such problems are considered,

(*Continued on page* 74)

A Special Library

MARGARET M. INGERSOLL, R.N.,



A corner of the library office showing the equipment for duplicating reference material and compiling a procedure book. The cupboard for filing and storing the stencils is also shown at the left.

A SPECIAL library is one that is organized to meet the needs of a specific group. It may combine professional and nonprofessional subjects, although for practical reasons we shall confine this discussion to the professional aspects. We based our selection of material for the library at Children's Memorial Hospital, Chicago, on the needs of the faculty and students as expressed in their requests for references on various subjects.

Pediatric nursing is a specialized subject. Texts and reference books for nurses are limited and, all too often, are brief in their discussions on the nursing care of children. At the Children's Memorial Hospital we ceased to require the students to buy textbooks and, instead, purchased for our library shelves several copies of various texts pertaining to child care. These include books on feeding and physical care, mental and emotional development and the clinical aspects of childhood diseases.

The authors are educational director and librarian, respectively, of the Children's Memorial Hospital, Chicago.

As the nurse's ability to help the child is incomplete without a knowledge of play, play materials, songs, games and stories, a collection of these books, which in part duplicates the copies in the children's library, was placed in one section. Also, in order to help the nurse become aware of her place in the community, we included books on phases of child welfare.

In 1932 we began the classification of these professional books with the guidance of the Boston Medical Classification. This is a standard classification for medical libraries that was adopted in 1920 by the Medical Library Association. The outline, which is in pamphlet form, may be purchased for one dollar from the Boston Medical Library. It offers a system that is easily expanded and adapted to nursing subjects. For example, 43 is the classification for books on nursing in general and 43D refers to specialization. In expanding 43D, as a symbol we added the first letter of the special kind of nursing about which the book was written; thus, 43Dp means pediatric nursing. This places all books on pediatric nursing together.

While the modern trend is to discontinue author numbers, we find it advisable at present to retain these because our library clerical assistance is untrained. The C. A. Cutter two figure author table arranges all books on the same subject in alphabetical order, so we use this identification along with the subject classification to aid in locating and lending the books by these numbers.

We have two types of card catalogs in the library. The first is a dictionary card catalog that gives the author and title of all books in the library, the simplicity of which makes it useful to the inexperienced as well as to the experienced student. The second is the subject card catalog, which consists of shelf list cards. This is in common usage in small libraries. It serves the purpose of locating all the books by the author on any subject in the library. For convenience, we have separated the professional books from the nonprofessional ones. For the use of special libraries we suggest printed

at Work

and ANN HOWE

cards without classification numbers because they save time and money. These cards may be obtained from H. W. Wilson and Company, New York, or from the Library of Congress, Washington, D. C.

The selection of subject material from current magazines is based on the clinical conditions seen on the hospital wards. Each new issue of a professional magazine is scanned for material. These articles are entered on 4 by 6 inch bibliography cards under the classified subjects identical with those of textbooks and are arranged alphabetically in a file. We substituted this index file for the Index Medicus because the material was actually on our shelves. Some of the material becomes permanent when, at the end of the current year, we bind certain of our professional magazines.

To enrich the reference material further, we were fortunate in obtaining many reprints of reported studies and lectures on specific conditions as supplements to texts. Typed copies of lectures prepared by the medical staff for our group are invaluable and at the same time inexpensive. Booklets, leaflets and reprints are listed on the same index cards under their respective subjects, making current reference material accessible. These are put into pamphlet boxes. The classification number is on the box, as well as on each article.

In developing the interest of our students in detailed aspects of nursing care, we have found it advisable to keep reference folders on the specific subjects touched upon in the classroom lectures and bedside clinics. A form was made up which could accommodate a summary of locations of the subject matter. We began by asking the instructors to write these references in duplicate, so that one copy could be used by the librarian as a notification of the material to be reserved or to be accessible. The original is put into a folder under the course title and is given to the student upon request at the library control window. This method proved popular with the students and instructors, so copies are typed in proportion to the class enrollment.

A student requests copies of the assigned class references from the clerk at the control window. This is one library that does not issue library cards.

The advantages of this scheme are as follows: (1) it avoids using class time for dictating references; (2) it makes references available at all times; (3) it allows the student to budget her study time; (4) it eliminates inaccuracy in listing subjects, titles and authors; (5) it helps the inexperienced library clerk in giving service to students, and (6) it serves to relieve the bulletin board of an accumulation of class references.

These reference folders have developed into a student body guide including outlines and suggestive questions submitted by the instructor. The librarian labels a pamphlet box to correspond with each course subject listed, as, for instance, "Conditions of the Muscles and Joints." Any unbound material other than professional magazines or bound books is placed therein. Additional material that is not assigned for class use but is of current and professional interest is kept on reserve for special requests. This takes the place of a vertical file.

To draw attention to new articles each month a reading list is selected by the librarian from professional magazines on such subjects as supervision, eight hour day or on special subjects about which there have been inquiries, as well as from topics in nonprofessional publications that may be of professional interest to the nursing staff as a whole. These lists are posted on the bulletin board. We have found the size of our bulletin boards, which measure 4 by 16½ feet, to be of advantage. This size al-

13Q	Edema	27M	Eczema
10L	Dysentery	22D	Drugs
11L	Diphtheria	16J	Digestive System
11M	Diarrhea	13D	Diabetes (Mellitus)
43Ba	Curriculums	20J	Croup Tent
18S	Crippled Children	43D	Convalescent Child
18Q	Congenital Dislocation of Hip	11A	Communicable Diseases
39E	Clinics	23N	Cleft Lip
19Fc	Chorea	14D	Chlorosis
39M	Children's Hospitals	26B	Children's Clothing
36W	Child Welfare Pamphlets		

Left: A section of the classified card index file. This system can be easily expanded and adapted to nursing subjects. Below: Book plate designed for the nurses' library.

lows for division headings, such as "nursing administration," "nursing education" and "library" and classifies material for quick reading.

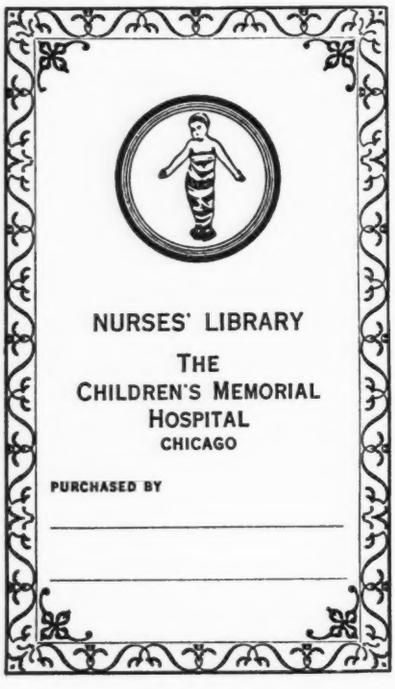
The librarian explains the facilities of the library to the students and new staff nurses during their orientation to the nursing department. As she conducts the library tour, she demonstrates that a specific reference folder is the guide to all professional material on that subject in both the library and the library control room.

Provision is made for lending reference books when the library closes for the night and on weekends and holidays. Our lending system is unique in that the borrower does not have a library card. We charge the book out on a loan card that is kept in the library office under the classification numbers. Through the classification number in the book, the loan card is located in the file.

A "date due" slip is pasted on the inside of the back cover and is stamped with the date of the loan. Money saved through elimination of book pockets and renewed library cards was used for an embosser or book plate to make the library more distinctive.

No fees are charged for the use of the library inasmuch as it was established for the members in residence. Provision has been made for the return of the overnight loans at the information desk in the nurses' home because the students go on duty before the library opens at 9 o'clock. Books that are turned in at this desk are sent to the library every day.

The cupboard that we use for the filing and storing of duplicating stencils and copies in flat trays may seem to be an expensive piece of equipment but it has proved to be a long-time economy and may serve all departments of an institution. We have found that one stencil can be used repeatedly and a six months' supply of clean, usable copies of all reference material can be run off at one time and stored until they are needed. Each department has a representative classification and a tray is used for every department or division.



The assembling of a procedure book which is offered as a guide to nursing care by schools of nursing is simplified by the construction of the cupboard. Each tray is equipped with a label holder for inserting a removable label, and materials can be systematically arranged for compiling the procedure book.

As we review our experiment in the development of a nursing school library, we realize the necessity for a trained librarian to give guidance and counsel. In addition, we have found membership in such organizations as the Special Libraries Association and the American Library Association of great value.

Another valuable service to nurses' libraries is a professional magazine exchange to facilitate the completion of volumes for binding. Nursing educators realize more and more the value of complete sets of bound volumes on nursing.

A summary of the contents of the library is easily assembled each year and is invaluable as history and as an inventory whereby we note our progress in the work of helping our nurses to pursue their education more fully by means of an easily used, informative library.

Convalescent Care Redefined

ERNST P. BOAS, M.D.

A FEW years ago convalescence was regarded strictly as "the period between a patient's acute illness and his return to his previous state of health," a definition that still stands as the accepted one in the minimum standards for convalescent homes. Convalescent care was provided for persons recovering from an acute infectious disease, such as pneumonia or typhoid fever, or from the effects of operative procedures. Patients were selected for whom one might expect complete cure and rehabilitation.

Care for Variety of Patients

The experience of convalescent homes during the past decade or so has demonstrated that such a definition is too narrow. Actually, convalescent homes are caring for a wider variety of patients, although they reject as unsuitable many who clamor for admission. Not the patients alone, but medical social workers and physicians, too, are constantly striving to extend the field of convalescent care.

Some homes have yielded, in part, to this patent need and are admitting patients who still require surgical dressings or special diets. Special institutions have been established to provide convalescent care for patients with certain orthopedic disorders and certain forms of heart disease. This has been an unplanned, unregulated growth. The broader concepts of convalescent care that have resulted have not yet been clearly formulated.

The best presentation of these problems and suggestions for their solution may be found in a report written in 1934 on "Convalescent Service in Relation to a Community Health Program" by Mary C. Jarrett of the Welfare Council of New York City. This report, unfortunately, has not been published but is available in mimeographed form.

Convalescent care must be regarded as an important tool of preventive medicine and should, as Miss Jarrett suggests, be enlisted to aid all types of recovery "whether from incipient or acute illness or from a chronic illness that may be retarded," as a result of which disability may be curtailed.

In the field of tuberculosis such a setup actually exists. Preventoriums are designed to prevent the development of tuberculosis in persons, chiefly children, who have been seriously exposed to infection. The care given resembles that of convalescent homes. When a person is acutely ill with tuberculosis he is placed in a sanatorium in the hospital section where he receives intensive medical and nursing care. As he improves, he gradually becomes semiambulant and then ambulant. Finally, although he is up and about and active, he is retained in the sanatorium for months to complete the arrest of his disease. This last stage is convalescent care called by a different name.

Preventive Care Helpful

The same principles that have been employed so successfully in combating tuberculosis can and should be extended to the treatment of a host of illnesses, particularly when poverty is an important factor either in the development of disease or in retarding recovery. Preventorium care, designed primarily to prevent the development of disease, should be particularly useful to patients in outpatient clinics, for instance, persons who are suffering from malnutrition or from subclinical forms of avitaminosis.

Chronic disease is an all-inclusive term and here, too, it is necessary to agree on certain definitions before we can profitably discuss the problem. From the point of view of care needed the chronically sick can be grouped into two large classes: those who need intensive medical and nursing care for prolonged treatment and those whose disease is stationary or very slowly progressive but who are left with some disability or physical handicap that makes it necessary to give them custodial care. The second group does not enter into our discussion. Such patients need a permanent home that is adapted to their physical handicaps rather than convalescent care.

The chronically ill persons who need active medical care comprise a large proportion of the patients in general hospitals and in out-patient clinics. Among them are many whose disease is inevitably progressive, *i.e.* patients with advanced cancer, with permanent heart disease or with chronically insufficient kidneys. Such patients, too, do not need convalescent care; they need permanent hospital care or its equivalent. But many chronic diseases run a course that is measured by years or even decades. Periods of relative well-being alternate with periods of illness. Following an acute exacerbation of the illness the proper sort of convalescent care may lead to complete or partial rehabilitation and may delay the progress of the underlying disease. Such convalescent care is an important therapeutic and preventive agent.

Many patients who happen to have a chronic illness also have an intercurrent illness, such as pneumonia or an operation, and need convalescent care after recovery from the acute intercurrent illness.

Providing for Acutely Ill

All of these subjects of chronic disease following an acute exacerbation of their illness or an acute intercurrent disorder should be given general convalescent care. It is true that the convalescent homes that receive them would have to provide more than the minimum country boarding house care that at present is all that is given in many institu-

Doctor Boas is chairman of the Committee on Chronic Illness, Welfare Council of New York City. Abstracted from a paper read before the Convalescence Conference at the New York Academy of Medicine.

tions. Proper dietary facilities and some forms of minimum medical supervision would have to be provided. Important, too, would be arrangements allowing for immediate readmission to the sending hospital of any patient who again becomes ill. These measures would not add greatly to the cost of conducting convalescent homes and would increase their usefulness in disease prevention and in the rehabilitation of the individual.

The establishment of special convalescent homes for the treatment of children with orthopedic disorders and those with rheumatic heart disease is evidence that these problems have received some recognition. These institutions differ from the conventional general convalescent home in that they make special provision for the medical needs of their patients. The orthopedic home is affiliated with an orthopedic hospital and receives patients after they have been treated in the orthopedic hospital, returning them to the hospital periodically when further treatments are necessary.

Homes for cardiac cases are more closely analagous to tuberculosis sanatoriums than to convalescent homes because they concern themselves with the long-time treatment of children suffering from rheumatic fever and its consequences. They must be prepared to give hospital, semiambulant and ambulant care. Rheumatic fever is a chronic infection with periods of activity and inactivity. Patients must be treated until the disease has become completely inactive.

At present, patients with acute rheumatic fever are treated in hospitals but, as a rule, they are discharged at a time when the infection is still smoldering. Far too often there is a recurrence of the acute symptoms within a few weeks after their return home or else a smoldering infection continues to be neglected for months. At present, most convalescent homes for children with rheumatic heart disease accept the patients only at a time when the disease is inactive, when they are probably least in need of such care. There is great need for institutions that will accept rheumatic patients during periods of subacute activity.

It is best to segregate rheumatic cardiac patients in separate institutions, for their medical needs differ from those of patients with other types of heart disease. In the case of rheumatic patients, one must deal with the problem of a chronic infection. In the case of patients with other forms of heart disease, the problems are primarily those of rest and nutrition. Many patients with a heart disease are run down or are convalescent from an intercurrent malady, although their cardiac function may be satisfactory. Such persons need only general convalescent care such as can be given in a general convalescent home. There are others who are recovering from an episode of heart failure or from an attack of coronary thrombosis, who have passed the acute stage of their illness but who need some weeks of rest and good food fully to recover their cardiac reserve. Such patients, too, need only general convalescent care but special attention must be paid to the amount of exertion they may undergo.

An institution is not the only means of providing opportunities for convalescence. Foster home convalescent care for children and a method of boarding out for adults may be very satisfactory. At present, the Speedwell Society is making an interesting experiment in convalescent care for children with rheumatic heart disease. Visiting housekeepers in the home provide another method of aiding convalescence. They offer relief to an overburdened mother and give her an opportunity to complete her recovery.

As with most voluntary institutions for the sick or for the well, convalescent homes have been established to fill a local need envisaged by some interested individual or group. Their development has never been integrated with the medical needs of the community or with existing health services. The chief stimulus for their growth has come from the social service field. Physicians have overlooked convalescent care as a necessary part of medical treatment and have made little use of available facilities. Today physicians are beginning to recognize convalescent care as an important implement to maintain health, prevent disease and hasten and complete recovery from illness.

Actual practice in convalescent homes has not yet caught up with this newer understanding. There is need to sharpen our concepts and to translate them into practice. First of all, physicians must accept convalescent homes as essential parts of the defense against disease.

Well-planned convalescent care fitted into the broader structure of medical practice will be a powerful ally to the physician in his efforts to prevent disease and restore health. With chronic disease responsible for more illness today, convalescent care must be realigned to meet this overwhelming and unmet need.

In Favor of Floor Secretaries

(*Continued from page 69*)

was not debatable on this occasion. It was apparent that the solution of this question lay in some other direction.

Effective nursing is a matter of vital concern in every hospital. Any steps that relieve the nurses of unnecessary distractions from their essential duties help to further and to promote adequate nursing activities.

In taking this action the Montefiore Hospital was aware of the fact that the nurses have completed an extensive course of training and are graduated only after a rigid curriculum has been followed. Such knowledge and training cannot be utilized to the greatest benefit of patients when interruptions are frequent and prolonged. Floor secretaries obviate such distractions from duty and form a substantial contribution to increased efficiency.

Some indication of the extent to which the presence of these floor secretaries has relieved the nurses may be had from glancing through the record on page 69 of a typical day's work in the obstetrical department, as itemized by the secretary.

Are Nurses Hard to Find?

BEFORE next July 4000 Red Cross nurses will be called to active duty by the United States Army. By or before that time every hospital in the country may feel the pinch of the first full-fledged shortage of nurses since the World War.

In many areas general staff nurses already are hard to find. During the first half of 1940 professional registries reporting to the American Nurses' Association were able to fill only 69 per cent of the "permanent" staff nursing positions listed with them.

Private employment bureaus report a similar shortage. A leading Middle Western bureau with a national coverage began to experience an acute shortage fully a year ago although, as the director points out, well-qualified nurses have been always at a premium for supervisory and general staff work.

Enrollment in the first reserve of the American Red Cross Nursing Service claims only nurses between the ages of 21 and 40, who are single, in good physical condition, registered in the state, members of the American Nurses' Association and graduates of a nursing school connected with a hospital having a daily average of at least 50 patients. By act of Congress these Red Cross nurses constitute the first reserve of the U. S. Army and Navy Nurse Corps.

To learn whether small hospitals are experiencing difficulty in providing nursing service at this time, questionnaires were sent to a number of hospitals in various sections during the latter part of September. From the tabulations on this and the following page it will be seen that most of the reporting hospitals have not yet been affected but, aware of what is coming, the superintendents are beginning to lay plans.

Four remedial measures are being contemplated: (1) use of subsidiary workers; (2) use of married nurses not now in practice; (3) salary increases to hold present incumbents, and (4) reopening of closed schools of nursing.

Many of the administrators questioned foresee the dangers that lurk in any one of these measures. Most of them caution against the use of nurses' aids for more than the most minor nursing duties. They realize, too, that if they are to bring married nurses back into the hospital they will have to institute an in-service training program to bring them up to date on procedures and technics. Moreover, both aids and out-of-practice nurses must be carefully supervised.

Salary increases may be of assistance in holding nurses not qualified or not called for Army service, the administrators concede, but they will put a precarious strain on the hospital budget.

The reopening of schools of nursing, too, will need to be done rarely and with ample forethought. It appears more advisable for existing nursing schools, particularly those affiliated with colleges, to increase their enrollments than for those smaller hospitals without proper teaching facilities or adequate teaching staffs to reopen schools or to increase enrollments.

Even before the preparedness program was inaugurated the output of nurses had begun to increase as a result of the law of supply and demand. The number of nurses graduated in 1935 was 19,600 and in 1939, 22,485.

Below is a tabulation of the present situation in regard to the threatened or existing shortage of nurses in 26 of our smaller hospitals.

HOSPITAL	No. of Beds	R.N. Shortage	Present or Proposed Solution	Enrolled for War Duty	Enrollee Age Group
			MIDDLE WESTERN STATES		
Alpena General Alpena, Mich.	74	Yes	Are forced to use nurses' aids. Will have to pay exorbitant salaries. Wish nursing schools would recruit more students.	9%	Older
Alton Memorial Alton, Ill.	75	Yes	Using married nurses now. Will consider nurses' aids and larger classes.	15%	Younger
Cass County Logansport, Ind.	58	No	Will increase salaries and train high school graduates for nurses' aid work and for minor nursing services.	12½%	Older
Charles Godwin Jennings Detroit	66	Yes, of qualified R.N.'s	Are hiring the best of the applicants and are training them according to our own standards. All staff nurses are given the in-service training program, now in its second year.	50%	Older
Eldora Memorial Eldorado, Iowa	16	Yes	Are employing married nurses in the locality. We may have to train nurses' helpers.	30%	Younger
Fairview Park Cleveland	130	No, but nurses are hard to find	We must accept inadequately trained nurses and, when a good one comes along, we pay $5 or $10 more to hold her. Added expense is balanced by better service to patients.	5%	Older

HOSPITAL	No. of Beds	R.N. Shortage	Present or Proposed Solution	Enrolled for War Duty	Enrollee Age Group
			MIDDLE WESTERN STATES—Cont.		
Flower Toledo, Ohio	120	Not at present	Shortage exists in our city, however.	Few	Younger
Mary Greeley Memorial Ames, Iowa	70	Not at all	The hospital maintains an extensive registry on which we can call.	Not yet	.....
Maternity Minneapolis	60	Not at present	We were short during the summer of 1939 and applied for Canadian nurses. We have considered subsidiary workers but have rejected the idea.	Do not know	.....
Willmar Willmar, Minn.	40	Not at present	Will attempt to get married nurses back into service. May possibly train practical nurses.	25%	.....
			EASTERN STATES		
Addison Gilbert Gloucester, Mass.	85	Occasionally	Asking senior class to remain for general duty nursing. Situation being studied.	14%	Younger
Alexander-Eastman East Derry, N. H.	21	No	Will use nurses' aids.	.....	.....
Amesbury Amesbury, Mass.	30	Not especially	Will take on subsidiary nurses or helpers.	None so far	.....
Brooklyn Women's Brooklyn, N. Y.	43	During vacation only	Hiring undergraduates. Will increase salaries if situation develops.	None so far	.....
Homeopathic Reading, Pa.	100	Yes	Increased salaries Sept. 1, based on rating schedule worked out after six months' study. Will encourage less qualified nurses to take further training. May reopen our school.	More than 50%	Both
Jordan Plymouth, Mass.	50	No	Will train nurses' aids.	1%	Younger
Middlesex Middletown, Conn.	140	Yes	Using own graduates as they finish. Accepting all accredited applicants. We may have to increase the number of subsidiary workers.	4%	.....
Princeton Princeton, N. J.	75	No	As a last resort would extend limited use of ward aids.	14	Younger
St. Luke's Middleboro, Mass.	31	No	One year ago started training attendant nurses.	None so far	.....
			SOUTHERN STATES		
Athens General Athens, Ga.	86	Not at moment	If compelled, will fill in with aids. Assembling roster of married nurses for emergency use.	30%	.....
Davis Pine Bluff, Ark.	53	Shortage just starting	We plan to reopen our training school, which was closed in 1932.	20%	Older
Leo Levi Memorial Hot Springs, Ark.	75	No	Will select graduates from our own training school.	None at present	.....
Missouri Pacific Little Rock, Ark.	125	No	We have an 8 hour (consecutive) day and pay slightly above the average in this section. Will place more attendants and nurses' aids on duty if necessary.	3	Younger
			MOUNTAIN PACIFIC STATES		
Denver and Rio Grande Western R. R., Salida, Colo.	80	No		20%	Younger
Longmont Longmont, Colo.	35	Yes	It will be necessary to train helpers for minor nursing duties.	1	Younger
Peralta Oakland, Calif.	145	No	Paying higher salaries than most hospitals. Graduate salaries start at $107.50 plus meal and laundry and mount to $115 at end of year.	50%	Younger

Protecting Patients' Records

MARGARET DuBOIS, M.D.

THERE has never been any question about the necessity for protecting the confidential material in a medical record from the public, but little has been done toward the establishment of a uniform code to be followed by hospitals in this connection. The natural result of this was that in all hospitals that conformed to the standards of the American College of Surgeons, records were kept under some system evolved in the individual institution, having little or no relation to the system used in a neighboring hospital.

While much has been accomplished in improving the quality, indexing and storage of medical records, surprisingly little effort has been made to improve the methods of protecting the confidential information within the records. True, the majority of record files nowadays are kept under lock and key and strict instructions are given the personnel of the record department to give out no information without the proper authority. This, however, scarcely seems adequate, as these instructions are based on the opinions of the individual hospital administrator or even of a group of hospital administrators and do not take into consideration the problems of those who are seeking information.

To these people, their side of the question is just as important as is the hospital's to the hospital. It is probable that few record librarians and possibly not many hospital administrators have a definite understanding of the law covering this matter. It is generally understood that the record, as a document, is the property of the hospital but, unlike a library book, its contents are legally "privileged communication" and, as such are not available for free perusal by any interested person.

Medical information from records is usually sought for one of the following purposes: (1) assistance in diagnosing and treating a patient's current disease; (2) investigation of insurance claims and applications for insurance; (3) settlement of medicolegal cases; (4) research, study and teaching, and (5) idle or malicious curiosity.

Taking these in the order listed, the following regulations have been adopted by University Hospitals of Cleveland:

1. Doctors or institutions requesting medical information in writing or in person and indicating clearly that the patient involved is at that time under their care are entitled to any information they request, subject to certain modifications.

In the case of a private patient, medical information is given only with the permission of the previous attending physician. No medical information is given over the telephone except in cases of definite emergency. In such cases, the name and telephone number of the doctor are taken and checked in the directory and he is called back. In rare cases, when a patient signs a request that no information be given, it will be necessary to have the patient's written consent to give information to a doctor or to an institution. Medical information is not given to employers' or company physicians without written consent of the patient.

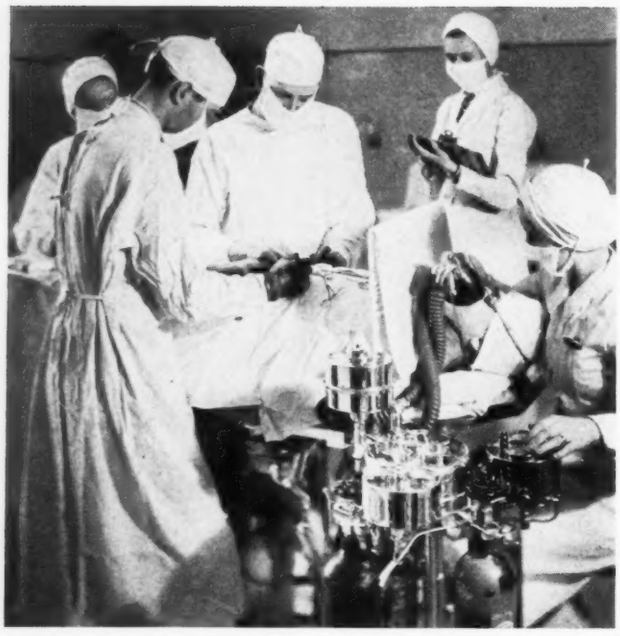
2. Medical information is given to insurance investigators, verbally or in writing, only upon receipt of written authorization from the patient and, in the case of a private patient, with the permission of the attending physician. No insurance investigator, whether doctor or layman, is permitted to see the medical record. No information is given over the telephone. No insurance company forms are filled out. Investigators for the Industrial Commission of Ohio, upon presentation of their credentials, are permitted to inspect medical records without restriction.

3. Medical information is given to attorneys under the same regulations as those that govern insurance investigators. Records are taken to court upon receipt of regulation court subpoena. Records are taken to an attorney's office upon receipt of a regulation notary's subpoena but must not be shown there except in the presence of attorneys representing both parties involved in the case. In the event of the court's requesting a photostatic copy of a record, the record is taken to the indicated pho-

Photographs from Grant Hospital, Chicago.

Students learn early that medical records are "privileged communications."

Doctor DuBois is in charge of medical records, University Hospitals of Cleveland.



The surgeon's report is dictated to the records librarian as the operation is completed. Some hospitals allow such records to be mailed to the physician to obtain his signature.

tostatic company by a records department clerk who waits for it and returns it to the hospital.

4. Medical records are lent to properly authorized persons by the medical records department of the University Hospitals of Cleveland on the same principles as books are lent by a public library. Whereas books, if lost, may be replaced by another copy, medical records cannot be replaced. The record borrowed is the only copy and precautions should, therefore, be taken against carelessness in leaving it lying around. In this connection it should also be remembered that a medical record contains confidential information and should not be available for reading by the public.

Records may be borrowed for a period of two weeks. If work is not completed at the end of this time, a renewal for two more weeks may be obtained on request.

A maximum of 20 records may be borrowed in one group and a second group of 20 may be obtained upon the return of the first group.

If possible, studies of hospital records should be carried out in the records room. The department is open twenty-four hours daily during the week and twelve hours on Sunday, and desk space is available after office hours. If records must be taken from the department, the definite location to which they are taken must be given to the record clerk. Studies on out-patient department records *must* be done in the department.

Never, under any circumstances, is a record permitted to leave the building except in the case of a subpoena to produce it in court or in a notary's office for a deposition.

Students who wish to review records must bring permission slips signed by their instructor. They are not permitted to take records out.

Any doctor who borrows records and does not conform to our regulations loses the privilege of borrowing records for a period of three months.

5. Medical information is given to no persons other than those listed except in case of written request from the patient and where the reasons for seeking information can be clearly shown. No information is given to a patient from his own record; he is referred to his physician for answers to his questions. A doctor is not allowed to see the record of his own illness except upon receipt of permission from his attending physician.

Should a patient be deceased, the signature of the nearest relative or that of a friend whose name was given on admission to the hospital is accepted as authorization to release medical information.

A charge of 50 cents is made by the University Hospitals of Cleveland to insurance companies and attorneys for standard reports, giving dates of admission and discharge, diagnosis, operation and subsequent recommendations. Copies of discharge summaries from hospital records cost from $1 to $2 and complete or partial transcripts of hospital or out-patient department records are furnished for $2 per hour.

While these regulations are more or less uniformly followed by the hospitals in this community there is, however, too much variation on some points. Such conformity as does exist is due to unwritten mutual agreement among representatives of the different hospitals.

In some hospitals attorneys and insurance investigators are permitted to read or to copy the record, provided they have the proper authority. This policy may or may not be better than that of the University Hospitals of Cleveland but, as long as the difference remains, there will always be annoyance and irritation on the part of these individuals when they are refused this privilege. In many hospitals doctors are allowed to carry records to their homes, offices or elsewhere when making case studies. Some hospitals mail records to their doctors for necessary signatures. Naturally, this leads to dissatisfaction among the doctors when such requests are refused.

It scarcely seems an adequate solution to have one individual or institution set up regulations for all to follow. These matters should be discussed on a national basis by a committee of hospital administrators, together with representatives of the medical and the legal professions and insurance companies. A code should be drawn up that is satisfactory to and approved by the majority in these groups and should be followed uniformly, subject, of course, to minor variations under existing state laws. If existing laws, state or federal, are found by this committee to be unsatisfactory, efforts should be made to have them revised.

Until these or other more effective steps are taken there will be no solution to this problm. The efforts of an individual to protect the confidential disclosures of the patient to the doctor are vain, except in a few isolated cases. The problem is widespread and, to cope with it, there should be an attempt to create a general sympathetic understanding of the situation among all concerned.

Balanced Reading Diet

Prescribed for Mental Patients

GORDON R. KAMMAN, M.D.

SEVERAL important factors must be considered in the treatment of patients suffering from neuropsychiatric disorders. The first step in the treatment program is isolation of the patient. This necessitates residence in a hospital. Being separated from all his former contacts, the patient is freed from the environmental stresses and strains that might have been causative factors in the development of his malady. He is placed in an environment that is much less highly charged with emotional values; he is freed from responsibilities, and a daily routine is worked out for him. Part of the daily routine includes a certain amount of time spent in reading.

Psychiatric Interviews

The second part of the treatment consists of a series of daily psychiatric interviews between the patient and his physician. These interviews are held privately and last for half an hour or an hour, depending upon the nature of the case. The physician may select any one of a number of psychiatric approaches, again depending upon the type of patient being treated and upon the nature of his trouble. Psychoanalysis has a limited application. It is a long, expensive procedure, applicable to only a limited number of disorders; furthermore, it requires a high degree of intelligence on the part of the patient.

Other psychiatric approaches endeavor to develop in the patient real insight into his condition and to teach him the true nature and meaning of his symptoms. Conflicts are resolved and through encouragement and reeducation the patient is gradually brought back to a life of usefulness to himself and to others. It is in the encouragement and reeducational phase that selected reading is of great importance and the wise psychotherapeutist will take advantage of the benefit to be derived from cooperation by and consultation with a competent well-trained specialist in bibliotherapy.

The author is assistant clinical professor of nervous and mental diseases, University of Minnesota. This paper was presented at the Tri-State Hospital Assembly, May 1940.

Improve Physical Condition

The third element is diet and medicine. Most patients are in a more or less dilapidated physical condition when they enter the hospital. They have not had sufficient food or rest, their digestive apparatuses are out of order and what little food they have taken has been imperfectly digested and absorbed. Furthermore, many patients are restless during the day and unable to sleep at night. For this reason, proper and adequate diet and appropriate sedatives are important features of the treatment. Before outlining a project in bibliotherapy for any patient the therapist should ascertain from the attending physician the physical condition of the patient and whether or not an intensive reading program would be likely to interfere with some other element in the treatment program.

The fourth step in the treatment may be described broadly as occupational therapy, recreational therapy and bibliotherapy. There is a growing tendency to take the development of reading projects out of the field of occupational therapy and to assign it to a specially trained bibliotherapist. I believe that this tendency to separate the two fields indicates a growing awareness on the part of physicians and hospital administrators of the importance of bibliotherapy. The division of library instruction at the University of Minnesota now offers an elective course in hospital librarianship. The course is now being given for the third time and I am informed that there is a constant demand for the services of librarians who have taken it.

Material used for bibliotherapeutic purposes may be divided into three classes: recreational, educational and therapeutic. In recreational reading we must be careful not to leave patients to desultory reading as they soon fall into a stultifying routine of newspapers and magazines and lose all interest. One of the most difficult of all patients to interest is the so-called "tired business man" who has never read anything but the daily papers. His mental horizon lies at the outer circumference of his business activities. He has been so busy making money that he has never had time for reading. Probably, that is one of the reasons why he is in a sanitarium. However, these men are frequently surprised by reading all about themselves in a history of the East India Company. Then, as they become more and more interested, they may take on Weston's "Horseshoe Nails," or Martin's "The Constant Simp." Later on they might even become absorbed in Feuchtwanger's "Power."

School Work for Adolescents

Educational books are used principally for young invalids who have not yet completed their schooling. There are a great many adolescents with mild psychoses requiring months of hospitalization who have many days during which they feel like studying. I recall the case of an epileptic boy from Winnipeg who because of the gradual development of an epileptic personality had to be hospitalized. He was in the hospital for more than a year, yet from an educational standpoint the year was not lost because the boy had been given books dealing with his school subjects and under the joint supervision of the hospital librarian and the occupational therapist made considerable educational progress.

The bibliotherapist's greatest opportunity for future development exists in the application of therapeutic reading. Psychiatrists, educators and librarians are beginning to cooperate in working out a scientific approach to the choice of the right reading for a given patient. When properly selected reading material is incorporated into the treatment program, bibliotherapy becomes an important adjunct and takes its place with occupational therapy and recreational therapy. I consider bibliotherapy to be a form of psychological dietetics. No definite formulas have as yet been worked out and much of our effort thus far has been devoted to teaching librarians what *not* to give patients to read. We know that literature that would be harmless or even beneficial to a well man might seriously interfere with the progress of a person suffering from a certain type of illness. To leave a mental patient to an unsupervised reading program may be as bad as leaving a diabetic patient on an unsupervised diet or a tuberculous patient on an unsupervised activity schedule.

In smaller communities in which hospitals do not have many adjuncts for the care of the sick, bibliotherapy assumes an even more important rôle. Almost every community has its public library and librarian; there may not be a therapist trained in the other auxiliary branches of medical treatment, but the librarian is always available. If she were familiar with the fundamental principles of bibliotherapy she could perform a service of great importance. She could be invited to consult with members of the hospital staff on reading assignments for individual patients. Group projects could be promoted, planned reading programs worked out and patients embarked upon a wholesome, diverting, instructive and constructive reading program.

In planning a reading project for a patient it is of paramount importance that the therapist know as much about the patient as is possible. Before seeing the patient she should have an interview with the attending physician and ascertain important facts about the trouble from which the patient is suffering, such as the nature of the illness, how long the patient will be incapacitated, the prognosis and whether he will be permanently handicapped. She should familiarize herself with any peculiarities or personality traits that will influence her approach to the patient; discover the presence or absence of suicidal tendencies or paranoid ideas, and learn something about the social and educational background of the patient, as well as his special aptitudes and interests. The physician should tell the therapist what results he expects from bibliotherapy, *i.e.* whether he wants the patient to be diverted, amused and educated along certain lines or whether he wants him to engage in a reading project that will indoctrinate him with certain principles and ideas which have specific therapeutic effect.

As an adjunct in the treatment of the mentally ill, bibliotherapy is sufficiently important to warrant special consideration on the part of the medical man. The physician should take the therapist to the patient and introduce her in person. He should arrange a preliminary interview between the therapist and the patient at which she can verify and supplement the impressions she received in her conference with the physician. At the same time the patient would have an opportunity to became acquainted with the therapist. We must remember that many patients are difficult and self-conscious. Many are in the hospital against their own wishes and one might find them in a resentful mood. Some are suspicious and hostile. Sometimes it is necessary for the bibliotherapist to make several short daily visits to the patient in order to arouse interest in reading projects.

Supervised reading for recreational, educational or therapeutic purposes is the latest addition to the physician's armamentarium for combating disease. The science of bibliotherapy is still in its infancy but I believe that it has possibilities for development far beyond the dreams of even its most ardent enthusiasts.

WOMEN'S SERVICE GROUPS

Emergency Aid Groups Formed

• Flash, flash—word comes of a brand new activity at Middlesex Hospital, New Brunswick, N. J., where the ladies' auxiliary is being divided into emergency aid groups. Classes of 30 women are being taught how to render simple services about the hospital. Not only are they made familiar with the various departments and their location, but in the training course, which totals twenty or thirty hours, they actually do practice work, such as taking temperatures, counting pulses and giving baths to patients. The idea is that in the event of emergency, they can be summoned to assist the regular nursing staff.

New Committees Helpful

• Two new committees have been added to the auxiliary of the Presbyterian Hospital in Newark, N. J., according to Mrs. Berdine, the president. First, there is the educational committee whose function it is to present a five to ten minute paper before each board meeting. Second, there is the nursery committee which writes a letter of welcome to the prospective mother telling her exactly what to bring with her for herself and what she will need to take her baby home. This group concerns itself about the "daddies," too, making the waiting room comfortable for them and supplying reading matter. Sometime we are going to get Mrs. Berdine to tell us about her Beauty Salon Service.

The Belles of Bella Bella

• The society belles of Bella Bella, British Columbia—all Indians and Japanese—have assumed the responsibility of collecting down from the wild ducks for hospital pillows, according to Dr. George E. Darby and Dr. G. Harvey Agnew.

Forty Workers per Week

• At the Hospital for Sick Children, Toronto, the Junior League supplies 40 workers each week to work in the clinics, to collect breast milk in various parts of the city and to give other assistance, Doctor Agnew reports.

Vase Shower

• The Community Garden Club of Newburgh, N. Y., has an annual vase shower for St. Luke's Hospital in that city. This, of course, is in addition to its self-assigned task of keeping fresh flowers in the lobby and on the wards during the entire gardening season.

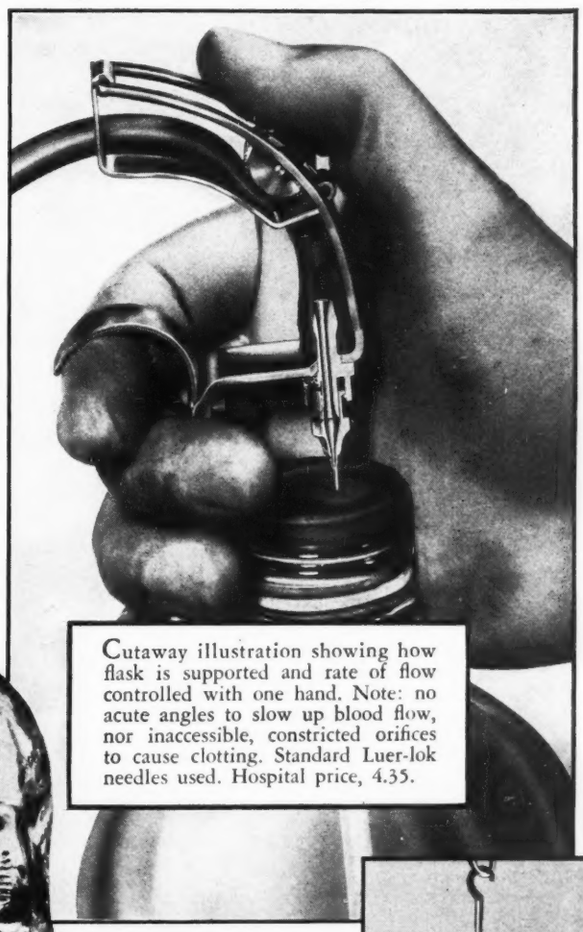
New Cutter Saftivalve ends transfusion grief!

THE new Cutter Saftivalve used in conjunction with the Cutter Saftivac brings to the transfusion field the simplicity of the hose-clamp method of controlling flow, universally used in the administration of intravenous solutions.

The Saftivalve handle allows the operator to firmly support and rotate the flask and control rate of flow with a single hand. There are no acute angles to offer resistance to the flow of blood, nor inaccessible, constricted orifices to cause it to clot.

The valving cap design of the Saftivac insures adequate vacuum to start with, while the entirely closed design of the Saftivalve prevents leakage of vacuum.

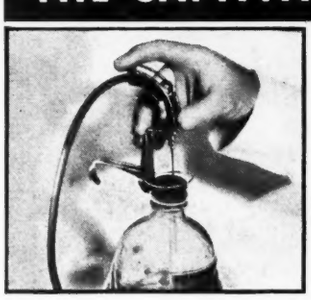
By a special process, developed by Cutter, each Saftivac is tested for high vacuum *after* it is sealed.



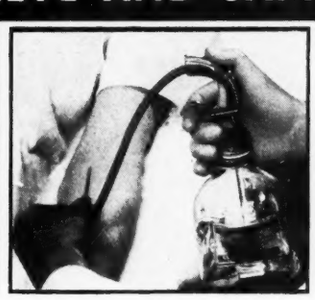
Cutaway illustration showing how flask is supported and rate of flow controlled with one hand. Note: no acute angles to slow up blood flow, nor inaccessible, constricted orifices to cause clotting. Standard Luer-lok needles used. Hospital price, 4.35.

Site for needle insertion readily apparent. Rubber cap covers top and lip of Saftivac, preventing contamination. Hospital price per Saftivac 1.20 to 85¢ depending on quantity.

THE SAFTIVALVE AND SAFTIVAC IN USE

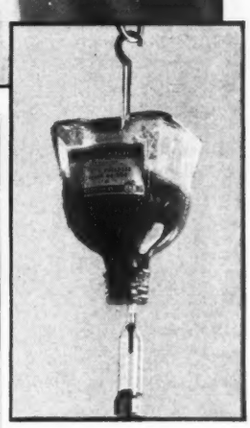


1 Valve needle is shoved through cap and diaphragm stopper opening, locking lever is then lifted up, which firmly attaches Saftivalve to Saftivac.



2 After donor needle is inserted in vein, valve wheel is opened until desired flow is obtained. Entire operation is then continued with the hand holding flask.

3 After blood is withdrawn, Saftivalve is removed leaving rubber cap in place. Saftivac may then be stored, or cap slipped off and transfusion started.

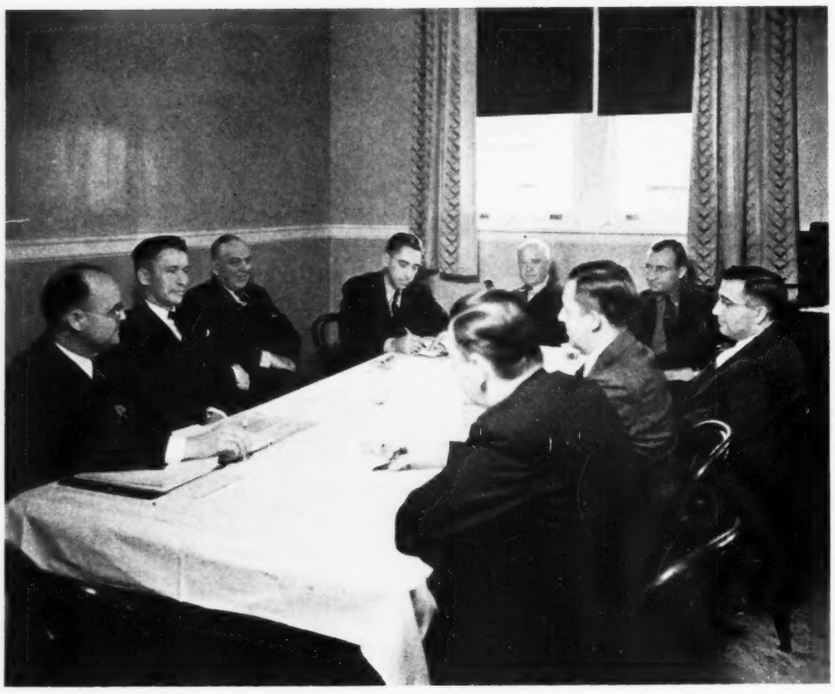


4 Blood is dispensed from Saftivac by attaching clot-filtering dripmeter to ordinary injection tubing outfit.

CUTTER Laboratories BERKELEY • CHICAGO • NEW YORK

Ten Commandments for Trustees

JOSEPH C. DOANE, M.D.



The final responsibility for the hospital rests with the board of trustees.

THE board of trustees cannot evade full responsibility for every act of the hospital's administrative and medical personnel. Specifically, it is responsible in the last analysis for the excellence, or otherwise, of every operation, every diet tray, every prescription, every lecture to nurses and every consignment of goods purchased. If surgical skill is mediocre, if nursing technic is bungling or if money is wasted in the power house or laundry, each trustee must share the blame.

A hospital board is usually composed of men and women who are accustomed to thinking in terms of profit or loss, to comparing figures inscribed in black and red ink. It is difficult for its members to think wholly in terms of dollars and cents at 9 o'clock in the morning and then to transform this interest into matters definitely expressed in terms of life and health of human beings at the monthly board meeting at noon. Some trustees naturally will tend to think of a good hospital as one that is blessed with a balanced budget or with splendid buildings. There are certain considerations, however, which should govern the activities of efficient trustees.

No member of the board of trustees should in any way seek personal aggrandizement from membership thereon. A real desire to forward the cause of disease prevention and cure should be the sole motive that activates their interest. The board's organization should be thoroughly worked out and the rules governing all of its activities should be recorded in a carefully prepared and printed book of rules. A blueprint of hospital organization showing the relationship of each individual to the whole should be prepared and placed in every departmental office in the institution. Strict lines for transacting routine business should be laid down. No official or personal communications should be permitted to come to the board except through the administrator. Every subcommittee, if it does not include the administrator in its membership, should work with and through him. Rounds of inspection through the hospital should be made only if the administrator or his representative accompanies the inspecting body. Surprise or clandestine night rounds in the absence of the administrator can lead only to discord, distrust and lowered morale.

It should be an unalterable rule that the board, having selected a well-trained efficient executive, should require that every member of the hospital staff recognize him as its official representative. If the board itself does not transmit business directly through this executive's office, it can be expected that others will seek to circumvent their own department heads or that department heads themselves will seek access to the board without the administrator's knowledge. The board of trustees is a policy-making body. It cannot permit its members to perform administrative duties and hope to maintain efficiency. No form of discipline should be attempted by the board or its subcommittees in the absence of the executive. Social contact between department heads and board members should be discouraged. Once having appointed the administrator, the board should support him or should discharge him.

There is a type of hospital trustee that endeavors to avoid making unpleasant decisions. The board that changes its policies like a weather vane is certain to head a hospital that is gossipy and of low morale and efficiency. To take a firm stand on a staff matter, thereby incurring the displeasure of a prominent and

influential colleague, or to demand the resignation of an ineffective but popular executive requires the exercise of spinal rigidity. On the other hand, to delay the day of decision or to seek for the easiest and pleasantest way out is to evade a duty placed by the community on every board member.

The administrator of the hospital should be held responsible for seeking out proper department heads and perquisites in the form of longer vacations or shorter hours. It should, however, have the wisdom to refrain from such action. Behind the scenes, it undoubtedly influences every act of the hospital executive. On the surface, the hospital executive makes the decisions and the board approves them after they are made.

The board of trustees should appoint staff members after consultation with the administrators. The tale-bearing attempts to circumvent the rulings of the hospital executive. The surest way to destroy morale is for the personnel of an institution to be made to believe that board members will deliberately humiliate the executive whom they have appointed.

It is the duty of the board of trustees to inform itself concerning certain basic facts relative to the scientific operation of the hospital. The board cannot adopt a policy of knowing and caring much about the physical operation of the hospital and deliberately remain ignorant about scientific affairs. It dare not, therefore, permit a sharp line of cleavage to be drawn between the scientific and the physical conduct of hospital matters. It should require reports from the chief of staff or from the staff committee on scientific affairs relating to the real results of medical and surgical treatment. Such a statement should contain information relative to morbidity and mortality statistics, postmortem percentages and the number of papers annually read and published by staff members. More detailed studies of scientific work could well be made from time to time. A board that is awake to the developments of institutional medicine may judge the effectiveness of the activities of its own staff.

In regard to physical administrative matters, subcommittees or even monthly visiting committees, if they exist, may well spend some time inspecting the hospital plant. By this means their members are able to learn at first hand the physical needs of the hospital as well as the reasons for certain institutional procedures. Moreover, their very presence in hospital corridors and wards in company with the administrator proclaims the existence of confidence in the latter and their desire for effective and cooperative work.

Generally, the commonest mistake in administrative work is to confound principles and personalities. It is not urged that the human side of hospital administration be overlooked and that each unit be considered as a mere cold and unfeeling automaton. On the other hand, human likes and dislikes, if permitted free rein, are common destroyers of efficiency.

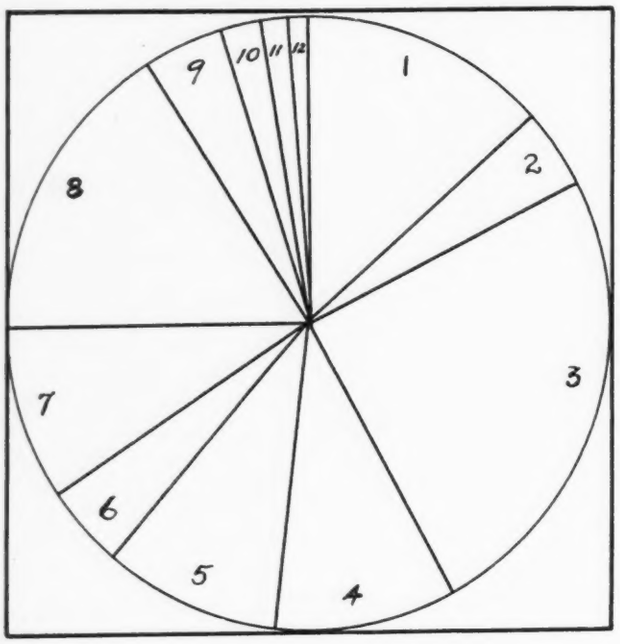
Decalog for the Board of Trustees

1. **The board of trustees should recognize the fact that it is responsible for every act, large or small, of the hospital's personnel.**
2. **No trustee should be permitted to use his membership on the board in order to further his own social or economic advantage.**
3. **The board should analyze its own organization carefully and see to it that its primary function of policy making is carried out with the greatest possible efficiency.**
4. **The board should employ a competent administrator and support him as long as he is retained. When it can no longer support his policies, it should not hesitate to dismiss him.**
5. **It should require job analyses and should prepare a blueprint of the hospital's organization.**
6. **It should contact members of the personnel only through the executive and, in turn, should insist that the only official way in which the personnel can reach the board is through this officer.**
7. **It should refrain from appearing to check on the hospital personnel clandestinely by making nocturnal rounds and should also refrain from making radical changes in hospital policy during the absence of the administrator.**
8. **It should allow the administrator to appoint or to discharge hospital department heads after conference with the proper member or committee of the board.**
9. **It should appreciate the value of a scientific inventory and should require periodic reports on the work of the medical staff.**
10. **It should recognize that the end products of hospital operation are disease prevention, care of the sick and public education in matters of health.**

for presenting their names to the board of trustees for approval and appointment. The president of the hospital board, for example, should not interview hospital workers alone nor should he make appointments. This is an administrative, not a policy-making, matter. It is not that the board of trustees does not have the right to engage and discharge workers, to raise their salaries, to improve their living conditions or to grant members of the staff should not feel that they are welcome to register complaints secretly with the board against members of the hospital personnel without the full knowledge of the administrator. Such complaints coming to the board should be referred to the administrator and the complainant should be informed of the fact that this is the policy that will be followed. It will take but few instances of this sort to discourage

Accounting for Maintenance Costs

PAUL R. WHITTEN and W. O. BOWMAN JR.



Left: The wheel shows how the engineering department's dollar is divided. Below: The trouble report on which all repairs that are to be done by the engineering department are ordered.

Form B-110

GRADY HOSPITAL
Atlanta, Georgia
TROUBLE REPORT

TO SUPERINTENDENT: Date 4/29, 1946

Please { Repair / ~~Furnish~~ } { ~~White Unit~~ / Colored Unit } ward III

State fully nature of trouble or need.

Repair wheel chair

THE cost accounting system of the engineering department of Grady Hospital, Atlanta, Ga., is entirely separate from that of the hospital. Its purpose is to indicate where each dollar charged to that department goes. The 12.6 per cent of the hospital dollar that is allocated to the engineering department is divided as follows: salaries, 13.38 per cent; wages, 4.48 per cent; fuel, 24.25 per cent; light and power, 9.70 per cent; water, 9.70 per cent; ice, 4.31 per cent; building maintenance, 9.16 per cent; building construction and repair, 16.16 per cent; equipment maintenance, 4.31 per cent; equipment and repair, 2.15 per cent; elevator, 1.40 per cent, and miscellaneous, 0.97 per cent.

This division, however, does not give a clear enough picture of the work that goes on behind the scenes to make an efficient and systematic study or comparison. In order to accomplish a detailed study we are inaugurating the following new procedures, the purpose of which is to trace and record the demands and usage of time, material and services to their ultimate end.

1. Trouble Reports: These are printed forms that are issued to the departments by the storeroom. Supervisors or employes fill them out and turn them in to their department heads who approve and forward them to the engineer. The engineer then classifies them, assigning an account code to each report. All construction or fabrication work is taken up with the superintendent for his approval and is rewritten on a numbered work order. The front of this order carries the date of approval, number, location and description of the work to be done, as well as space for the dates on which work is started and finished and by whom done. The reverse side of the order is shown at the bottom of page 86.

On this sheet, the total cost of material checked out of the storeroom is entered under "stock," the cost of material bought specifically for that one work order is listed under "direct" and the value of material that is salvaged or is not obtained from stock or purchased is entered under "other." Under "remarks" is always noted the amount of any labor hired for that work order. Normally, all labor is provided by the maintenance crew.

2. Job Clock and Cards: Each workman has his individual number, card and card holder. He clocks each time he changes duties or peforms a different operation. This clock, calibrated in tenths of hours, gives an accurate record of the workman's time and affords the engineer a simple means of allotting the time to the proper account. It has also turned out to be invaluable in another way. Whenever it is desired to find a specific workman, all one needs to do is to look on his card to see where he is working.

If a workman is called from an assigned job to an emergency call, he need not return to the shop and reclock his card but telephones the shop and has someone clock "out" and "in" for him. The cards are also

Mr. Whitten is statistician and Mr. Bowman is chief engineer of Grady Hospital, Atlanta, Ga.

Month - Year -	1 B-c	2 B-m	3 B-r	4 P-c	5 P-m	6 P-r	7 E-c	8 E-m
1 White Hospital								
2 Colored Hospital								
3 Contagious Hospital								
4 White Clinic								
5 Colored Clinic								
6 White Nurses Home								
7 Colored Nurses Home								
8 Employes Quarters								
9 Intern Quarters								
10 Educational - Nurses								
11 Educational - Medical Stud.								
12 Administration								
13 Central Supply Room								
14 Main Labatory								
15 White X-ray								
16 Colored X-ray								
17 Kitchen								
18 Laundry								
19 Storeroom								
20 Ambulance Service								
21 Shop								
22 Grounds								
23								
24								
25 TOTALS								

THESE ACCOUNTS CONTINUE ON UP THRU 20 →

used for pay roll purposes when day labor is called in.

3. Material Reports: These are filled out by the storekeeper if the material comes from stock; by workmen if it is taken from salvage bins, and by the engineer if it is a direct purchase or charge.

Only material for one work order or one account is placed on a single material report. All material for a day's work is drawn out at one time.

4. Meter Readings: Each of the 22 units of the hospital is metered for light and power, steam and hot and cold water. Every month, when the hospital meters are being read by the public utility representative, a hospital employe reads and records the unit meters, the hospital bill for that service being prorated according to the unit consumption.

Above: Expense sheet; key letters indicate work done. Center: Work order. Below: Material report.

WEEK ENDING	MATERIAL				LABOR	TOTAL	REMARKS
	STOCK	DIRECT	OTHER	TOTAL			
TOTAL							

MATERIAL (STOCK) _____
" (DIRECT) _____
" (OTHER) _____
_____
LABOR _____
_____
TOTAL

CHARGED _____
DATE _____
BY _____

DISTRIBUTION

JOB NO. _____ DATE _____

ACCOUNT _____ MATERIAL REPORT SOURCE _____

GRADY HOSPITAL ATLANTA GA.

NO	DESCRIPTION	UNIT	COST

The originals of all forms are turned in to the engineer after they have been executed. Time cards and material reports are handled by the week. The 20 accounts of the 22 units are then distributed as shown on the accompanying expense sheet.

A separate expense sheet is filled out for each month. The easiest way to do this is to keep the accounts posted weekly. This is done by filling out copies of the reverse side of the work order for each account and by posting to them each week the charges to that account from the time cards and material reports. This may seem to be a duplication of the posting of time and material on the account work orders and the numbered work orders from the time cards and the material reports. To eliminate duplication, the numbered work orders are posted first, setting aside the material reports posted and circling the time on the card line in red. Then, when the account work orders are posted, the remaining material reports and the time that is not circled on the card are entered. In this way, a numbered work or-

A floor of Nairn Veltone Linoleum brings charm and dignity to the living-room of St. Mary's Hospital, San Francisco, Cal.

QUIET FLOORS MEAN QUIET HALLS

IN HOSPITAL CORRIDORS, where quiet is of prime importance, resilient floors of Nairn Veltone Linoleum reduce noise and clatter to a minimum. The same quietizing qualities, plus its proven ability to give long, satisfactory service, also make it the ideal floor material for nursing schools of hospital institutions.

In addition, Nairn Linoleum is completely sanitary . . . footeasy . . . distinctive in appearance . . . easy to clean . . . economical to install and maintain. It is available in a wide range of beautiful colorings to fit any individual requirement of interior design.

Installed by Authorized Contractors, Nairn Linoleum is fully guaranteed. CONGOLEUM-NAIRN INC. KEARNY, NEW JERSEY

Nairn Veltone Linoleum creates an effect of greater light and spaciousness for this corridor in St. Mary's Hospital, San Francisco, California.

NAIRN LINOLEUM • Floors and Walls

REG. U. S. PAT. OFF.

der is completed, totaled and charged to its proper account. However, when a work order lasts through several months, as many do, and is finally completed, the account for that month would include the labor and material that were used over the duration of the job. In order to avoid this, the numbered work orders are posted monthly to the account work orders and a red balance line is drawn on the numbered work orders, designating the end of a month and its cost posted.

The monthly sheet is then filled out from the totals of the account work orders and the prorated meter readings. The total of this gives the labor, supplies and materials used during that month. It cannot agree with the charges to the engineering department by the hospital accounting department because the hospital accounting department charges the materials bought during the month while the engineering department cost accounting shows materials used and also shows the value of salvaged materials.

The total cost of initiating this system is too much to be absorbed in a single year, for it is expensive to buy and to install meters, not to mention the charging of lines to get each unit's supply through its own meters.

Let us see what happens after the system has been installed. What will the monthly expense sheet show and what can we obtain from it after it is in operation? Monthly comparisons between the same accounts of the various units, bearing in mind the construction of the building, its usage, occupancy and any construction ordered, together with comparisons of the previous month's unit account, will give a perfect picture of how operating costs are running. An erratic jump in the electric bill can be found in the unit immediately. Building and furniture repair and maintenance, a costly item, can be watched and, by comparison and cooperation with unit department heads, the occupants of the units that are running high can be advised, cautioned or educated into a better method of caring for their surroundings. There is no end to the various studies that can be made from the monthly expense sheets. Savings effected through these studies will soon amortize the expense of installing this system.

Washing Out Static Sparks

A. KOLIN

SPARKS resulting from static electrical charges are a frequently reported cause of ignition of explosive anesthetics. From 102 incidents listed by Livingstone, Shank and Engel, 34 ignitions were caused by "static sparks." Various recommendations have been made which aim to counteract the accumulation of static charges on objects in the vicinity of the operating table.

The recommendation of a high relative humidity is based on the fact that, under such conditions, a thin layer of moisture is established on the floor and on the surface of other objects. This layer conducts electricity well enough to permit the electrical charge acquired by an object to leak off to the ground along the moist surface before it has a chance to escape as a spark to an object at a different electrical potential. However, it has been found that a high humidity in the operating room does not offer absolute security from static discharge.

Other means have been recommended to equalize the potential differences between the persons and objects near the patient. These include the Horton intercoupler and built-in brass strips in the floor. The intercoupler, however, takes care of only a limited number of objects. The brass grille, incorporated in the flooring, has been described by Herb, who recommends a structure of brass strips joined with brass and grounded. These strips must be close enough to ensure constant contact between them and the shoes of the personnel.

We should like to call attention to a simple method of obtaining the effect sought by Herb. If the floor of the operating room is washed with a solution of calcium chloride, a hardly perceptible layer of $CaCl_2$, which is highly hygroscopic and which will leave a layer of moisture on the floor even at a low degree of humidity, will remain after drying. The presence of calcium and chlorine ions greatly increases the conductivity of this layer.

Mr. Kolin is a physicist at Mount Sinai Hospital, New York City.

Our tests have shown that a porcelain or tile surface washed with a solution of calcium chloride retained its conductive property for many weeks. We have demonstrated the continuation of this conductivity for twelve weeks after the last application. Treating the floor of the operating room in this way tends to prevent the establishment of electrical potential differences between any persons or objects anywhere in the room. No extra labor would be necessary in the care of the floor inasmuch as a solution of calcium chloride of about 4 per cent concentration would be substituted for the usual cleaning solution used for mopping up the floor between operations.

During the months of June, July and August when the relative humidity is increased, the concentration of the calcium chloride solution can be reduced to .25 per cent or less, according to the climatic conditions.

Another method of reducing the accumulation of static charges has been suggested by Connell and H. B. Williams, who recommend moistening the rubber conduits and breathing bags of anesthesia machines with a 4 per cent solution of calcium chloride.

Scheuerlen and others have warned against the use of rubber soled shoes in operating rooms since, owing to the insulating properties of rubber, electrical charges would not so readily leak off to the ground. However, for those who wish to avoid wearing uncomfortable, hard-soled leather shoes, we suggest perforating the soles of rubber or composition-soled shoes with fine holes, thus establishing a conductive contact between the person and the floor through these moistened channels in the perforated sole.

It is not advisable to depend on perspiration alone to keep the channels moist and, hence, it would be well to moisten them and the soles at three day intervals with a saturated solution of calcium chloride. A pipe cleaner is excellent for moistening the channels.

Food Service Moves Swiftly

at St. John's Hospital, Springfield, Ill.

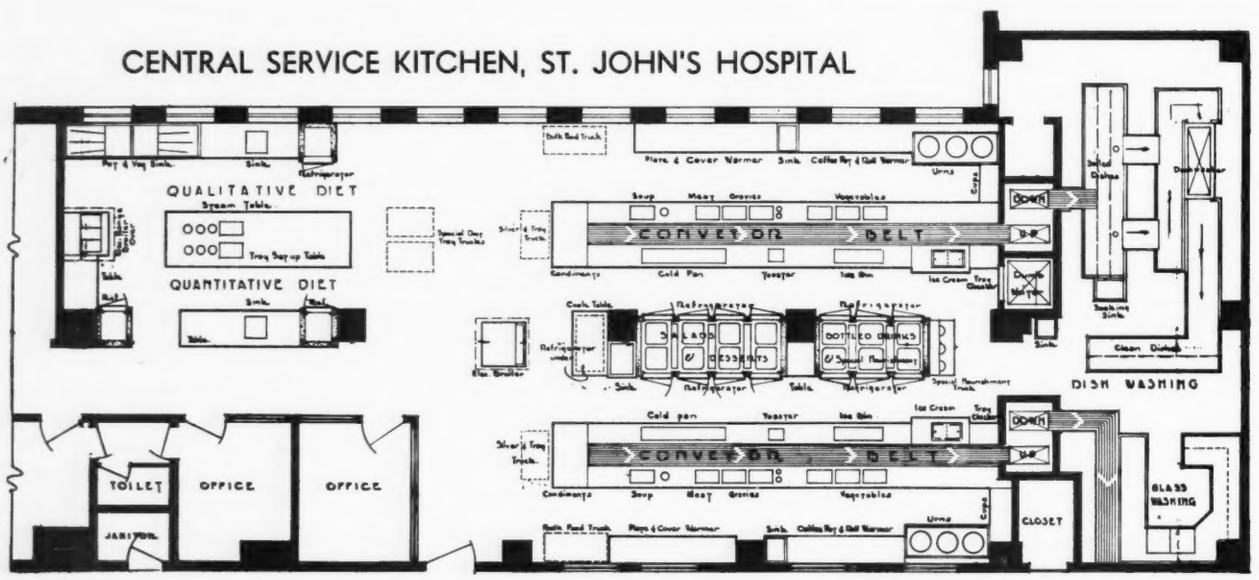
A general view of the south end of the kitchen. The counter for serving hot foods is at the right side of the conveyor belt and the cold food counter is at the left.

THE central serving kitchen in St. John's Hospital, Springfield, Ill., an institution of 556 beds, is one of the most efficient of its kind in the world. It was designed with but one thought in mind—to give the best possible service to patients in the shortest time that is humanly and mechanically possible. Stainless metal was used for all equipment and the latest and most modern of mechanical appliances were adopted after a careful study and test.

It will be noted from the accompanying plan that the entire service centers around two conveyor belts, each approximately 30 feet long, which move at a speed of 30 feet per minute. They terminate in an automatic tray lift that picks up each tray from the belt by means of moving angle cleats on each side. To prevent confusion the trays are automatically spaced just before entering the tray lift housing.

Both conveyor belts serve every floor and section of the hospital and both have openings on every floor.

CENTRAL SERVICE KITCHEN, ST. JOHN'S HOSPITAL



Two belts are used, first, because no single belt could take care of the quantity of food that is distributed and, second, because it was felt that two separate belts represented a safety factor in case one should be out of commission. Each belt serves four floors, one floor at a time, starting with the highest one in each case and working down.

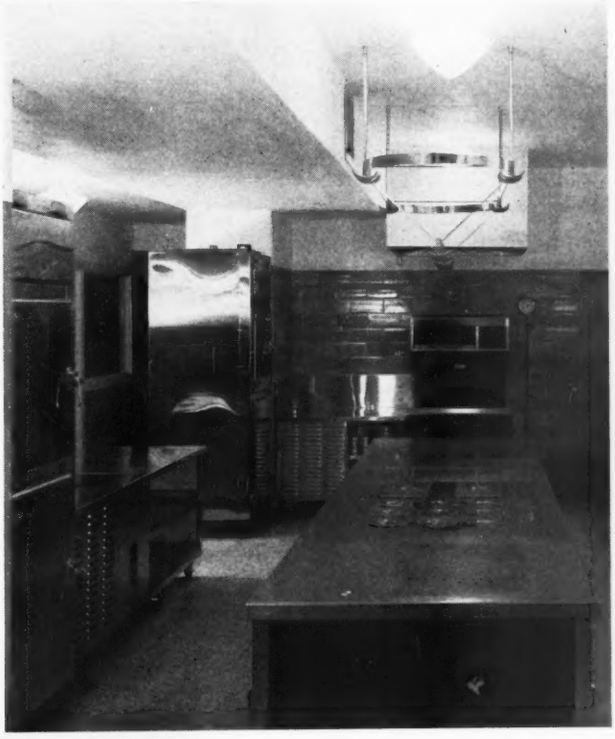
A control board equipped with ruby light indicators and jack-plug sockets for each floor is located just to the left of each tray lift opening. By inserting a jack-plug in the proper socket, the tray checker stops the trays at the desired floor. The jack-plug lights a photo-electric cell on the floor selected and when the tray reaches this floor it breaks the light beam and stops the lift until it has been removed.

Automatic dial phones interconnect each floor serving room with the central serving kitchen so that prompt action and communication can be had at all times.

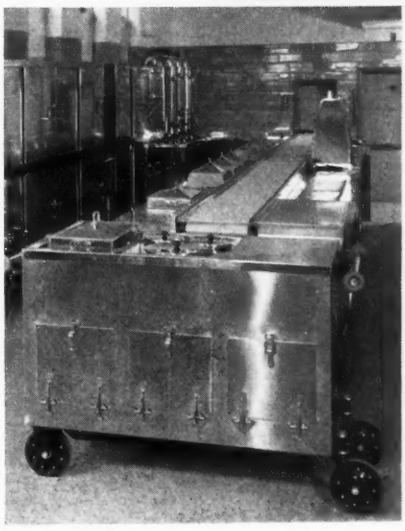
One side of each belt is devoted to the service of hot food and the other, to cold. The counters on each side of the belts are of a convenient working height and are narrow so that servers can easily reach over them and deposit food on the moving trays. The counter tops are of heavy stainless metal joined to the conveyor frame. The counter bodies are of stainless steel with open shelves below. All equipment is mounted on high cast white metal legs so that the floor can be cleaned easily.

The hot food is held in electrically heated units. Behind the hot counters along the walls are arranged high warmers with sliding doors to heat plate covers, coffee pots, plates and cups. One section at the end is fitted with lift roll doors for keeping rolls hot. Coffee urns are placed at the end of the line, with space below for heating additional cups and saucers.

The cold counter is fitted with a refrigerated cold pan of proper width and depth to take standard stainless metal oblong inserts. These are for cold foods, such as potato salads and cold cuts for summer service. When not in use, these cold pans are covered with flush stainless metal tops. A large automatic gas toaster is located in the center and bread of all kinds is kept in suitable receptacles



Above: The battery of refrigerators in which salads, desserts, butter, cream and beverages are placed prior to serving. Center: The steam table and tray setup table at which qualitative diets are served. Below: One of the electrically heated trucks in which food is brought from the kitchen shortly before mealtime.



below the counter at this point. A bin for the storage of crushed ice is also included. An ice cream cabinet is placed near the end of the line and, in order to speed up service, only packaged goods are used.

Behind the cold counters, in the center of the room, is a large battery of special refrigerators. These are made to accommodate 16½ by 22½ inch trays. The refrigerators are covered inside and out with stainless metal and have large vertical fin coils behind door mullions. They hold salads, desserts, butter, cream, jellies, relishes and bottled beverages on trays, which have been filled and

placed in the refrigerators prior to the serving hour. Empty dishes and glasses are also stored herein to be chilled for service.

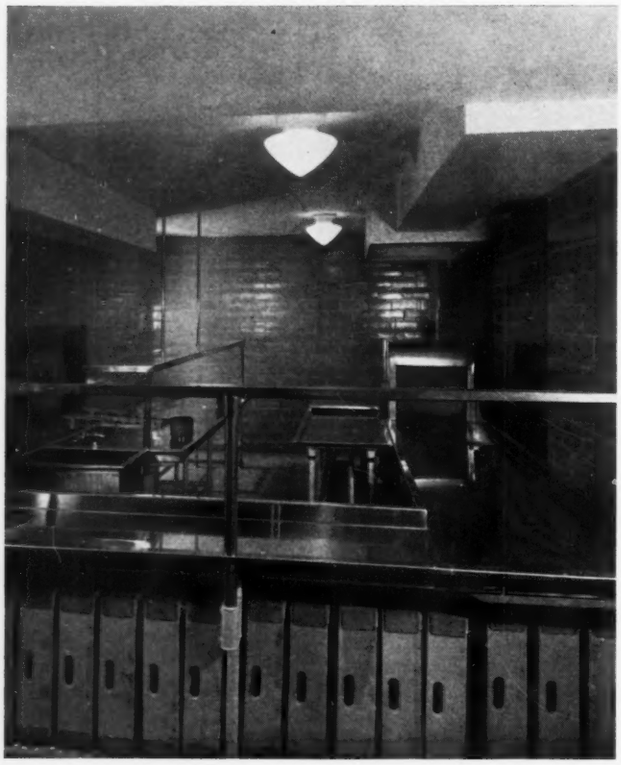
At the end of each belt is a stand for silver, salt and pepper shakers, tray cloths and napkin rings. This is supplemented by especially designed stainless metal trucks to hold additional quantities of these materials, which are wheeled into an adjacent position when service begins.

A large electric broiler and a work table, which has a refrigerator below, are at the starting end of the belts in the center of the room. Here chops and small steaks are broiled. These are transferred to the hot food wells, a few at a time, as needed, so that they are always served hot.

Special diets, both qualitative and quantitative, are handled at the opposite end of the kitchen. Each department has its own equipment and fills its own trays. Trays are laid out and filled on multiple shelf carts. When completed they are transferred to the belt and proceed to the floors in the same way as a standard tray.

Between-meal nourishments are handled on a special utility truck, fitted with a toaster, juice extractor, malted milk mixer, hot plate and glass coffee maker. This truck is wheeled into position at the end of the refrigerators. Food materials for this purpose are kept in the end compartment of the refrigerator.

Orders are written up on each floor and are sent down a pneumatic tube to the kitchen where they are filled and sent back by the dumb-waiter. These orders are written on a counter ticket recorder in triplicate. One copy stays in the recording machine and the other two are sent to the kitchen, where one is retained and the other is sent to the accounting department when priced. A small slip with the room number, date and time is all that is returned with the filled order.



Soiled dishes are returned to the dishwashing department on the lift shown at left. First, they are put in the soaking tray, after which they are washed in the automatic dishwasher. The counter shown in the foreground is for clean dishes.

The entire tray and soiled contents, with the exception of the glass, coffee pot and salt and pepper shaker, are returned to the dishwashing department on the "down" side of one tray lift. The accumulated glasses, coffee pots and salt and pepper shakers are returned on the "down" side of the other lift on separate trays. Dishes, trays, silverware and covers are washed and sterilized in a large automatic stainless metal dishwasher of the basket type. Glasses are washed and sterilized in a revolving brush glasswasher. All are then returned to the warmers, refrigerators and trucks, ready for the next serving.

Menus are planned several days in advance. In the morning of each day, the floor nurse presents the following day's menu to the patient for selection. The patient's choice for the three meals is written up on an order form. All orders must reach the serving kitchen before noon, where the necessary records are made and a requisition is sent to the main kitchen for the number of servings on each item. An allowance is, of course, made for any new patients who may be admitted to the hospital overnight.

The meal orders are sorted by floors and then cut in three parts, one for each meal.

Between meals all salads and desserts are prepared and dished up. Dishes are placed on trays in refrigerators. Trays of bottled milk, chocolate milk and fruit juice are filled and stored in the refrigerators ready for the ensuing meal. Butter is cut and put on patties. Creamers and jelly cups are filled and stored away in the proper compartments of the refrigerators.

Ten minutes before mealtime, the hot food arrives from the main kitchen in especially designed electrically heated trucks that hold the complete and filled steam table inserts. The inserts are quickly transferred to the serving counter, the hot wells having been previously heated, and the truck is plugged in at the space provided for it to keep the remaining food or extra pans hot.

A tray of each salad, dessert and beverage, as well as butter and similar materials, is removed from the refrigerators and placed on the counter. Stacks of soup bowls and covers, plates and covers, vegetable dishes and covers, cups and saucers and coffee pots are removed from the warmers.

At the appointed hour the belt is started and service begins. One person takes a tray from the tray storage truck, places a cloth thereon and passes it to another, who adds silverware, salt and pepper shakers and a single portion envelope of sugar. A third person places a napkin ring, the first china underliner and a patient's meal order on the tray and starts it on its way. Thus, for the first time in its long journey the tray is consigned to a definite patient.

As the belt moves past each server, she looks at the order and places the item called for on a tray. Enough servers are provided so that no one person has to place more than one item on a tray, although that person may have more than one to choose from, such as a variety of meats, vegetables, bottled goods and bread.

The servers are divided about equally between regular kitchen employes hired for this work and nurses in training. The nurses rotate every few weeks so that all get a thorough training in food service and learn to appreciate the importance of writing orders legibly and of handling them promptly.

Coffee, tea and cocoa are served in individual vacuum jugs or servers. A hot cup and saucer are placed on each tray with the vacuum jug.

Just before the trays enter the tray lift, a checker looks them over carefully. If a tray is not properly filled, it is removed from the belt or the belt is stopped with an emergency switch on a control panel beside the checker until the missing item has been added by an attendant.

During the service, an attendant patrols the aisles, replacing covers, plates and cups as they are used in order to avoid the necessity of the server's leaving the belt for these replacements. It was found that this was a vitally important point in the operation of the system, for at no time can the servers leave the belt without causing confusion and delay.

When the last tray for a floor has been started down the belt, a stack of three empty trays is placed on the belt to follow it. These trays are used in the floor serving room to accommodate the glasses and coffee pots at the conclusion of the meal. They also serve as an indicator to the attendant on each floor that she has received the last of her trays. Furthermore, when the attendant on the floor below or the next floor to be served sees these three empty trays go past in the shaft, she knows that the next full tray will be the first one for her floor.

At mealtime, student and graduate nurses from two or three floors gather in the serving room of the first floor to be served. They form in line ready to receive the trays as they arrive from the kitchen. The supervisor of the floor being served checks off each tray by room or ward number as it arrives from a previously prepared list to be certain that all have been received. The nurses take the trays, in turn, to the proper patients and return to the serving room promptly and enter the end of the serving line.

When all patients have been served, the servers go quickly to the next floor and the process is repeated. Each floor supervisor remains on her own floor, however, and directs the service for that floor only.

For the first few weeks when the system was being organized, trays were served at the rate of 10 per minute. Within six weeks, this had been stepped up to 12 per minute and it is expected to remain around that figure, with a possible slight increase.

Food Cost Tables—Staples

GRACE STOWELL SAUNDERS

RICE—Polished

	COSTS, AS PURCHASED																		
*1 lb.=2½ C.	.04	.0425	.045	.0475	.05	.055	.06	.065	.07	.075	.08	.085	.09	.095	.10	.105	.11	.115	.12
1 C.	.0182	.0193	.0205	.0216	.0227	.025	.0273	.0295	.0318	.0341	.0364	.0386	.0409	.0432	.0455	.0477	.05	.0523	.0545
½ C.	.0091	.0097	.0102	.0108	.0114	.0125	.0136	.0148	.0159	.017	.0182	.0193	.0205	.0216	.0227	.0239	.025	.0261	.0273
¼ C.	.0045	.0048	.0051	.0054	.0057	.0063	.0068	.0074	.008	.0085	.0091	.0097	.0102	.0108	.0114	.0119	.0125	.0131	.0136
*1 oz.=2 T.	.0025	.0027	.0028	.003	.0031	.0034	.0038	.0041	.0044	.0047	.005	.0053	.0056	.0059	.0063	.0066	.0069	.0072	.0075
½ oz.=1 T.	.0013	.0013	.0014	.0015	.0016	.0017	.0019	.002	.0022	.0023	.0025	.0027	.0028	.003	.0031	.0033	.0034	.0036	.0038

*An average as per a number of experiments has been chosen: 1 lb. = 206.6 grams; 1 T = 14.5 grams.

MACARONI—Elbow

	COSTS, AS PURCHASED																		
20 lbs.=1 box	.80	.90	1.00	1.10	1.20	1.30	1.40	1.50	1.60	1.70	1.80	1.90	2.00	2.10	2.20	2.30	2.40	2.50	
*1 lb.=4 C.	.04	.045	.05	.055	.06	.065	.07	.075	.08	.085	.09	.095	.10	.105	.11	.115	.12	.125	
½ lb.=2 C.	.02	.0225	.025	.0275	.03	.0325	.035	.0375	.04	.0425	.045	.0475	.05	.0525	.055	.0575	.06	.0625	
¼ lb.=1 C.	.01	.0113	.0125	.0138	.015	.0163	.0175	.0188	.02	.0213	.0225	.0238	.025	.0263	.0275	.0288	.03	.0313	
¾ lb.=3 C.	.03	.0338	.0375	.0413	.045	.0488	.0525	.0563	.06	.0638	.0675	.0713	.075	.0788	.0825	.0863	.09	.0938	

*An average as per a number of experiments has been chosen: 1 C = 110.6 grams.

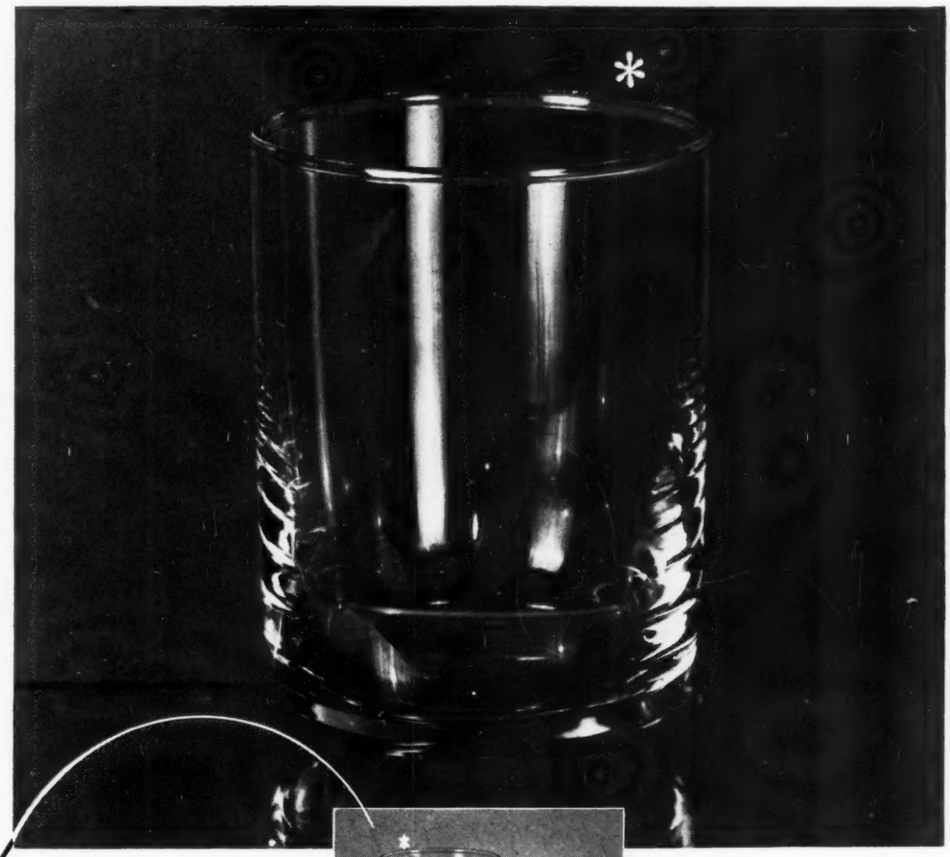
CORNSTARCH—Pulverized

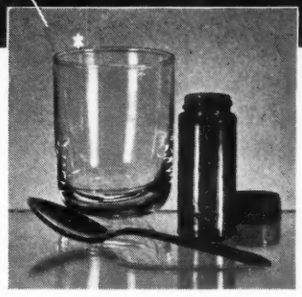
	COSTS, AS PURCHASED									
*1 lb.=3 C.	.035	.04	.045	.05	.055	.06	.07	.08	.09	.10
½ lb.=1½ C.	.0175	.02	.0225	.025	.0275	.03	.035	.04	.045	.05
⅓ lb.=1 C.	.0116	.0133	.015	.0166	.0183	.02	.0233	.0266	.03	.0333
⅙ lb.=½ C.	.0058	.0067	.0075	.0083	.0092	.01	.0117	.0133	.015	.0167
*1 oz.=3 T.	.0022	.0025	.0028	.0031	.0034	.0038	.0044	.005	.0056	.0063
½ oz.=1 T.	.0007	.0008	.0009	.001	.0011	.0013	.0015	.0017	.0019	.0021
*1 t.	.0002	.0003	.0003	.0003	.0004	.0004	.0005	.0006	.0006	.0007

*An average as per a number of experiments has been chosen: 1 C = 153.25 grams; 1 T = 8.55 grams; 1 t = 2.7 grams.

Learn Why Patients and Hospitals Alike Prefer This Special Libbey Tumbler

We want you to have one! Mail coupon below for free sample.





YES! This tumbler provides special service for hospitals. Made of sparkling, thin glass with heavy sham bottom, its low wide shape and the way it *feels* appeal to patients. You'll like it because it's rounded inside to permit easier stirring—better cleansing. The low center of gravity prevents tipping.

There's economy for you in the Genuine Libbey Safedge—6 times stronger than sidewalls—which saves you from loss by chipping. Like all Libbey glassware this tumbler is pre-tested for resistance to thermal and mechanical shock. Libbey Glass Company, Toledo. Branches in New York, Chicago, Detroit, Atlanta, Dallas, San Francisco, Toronto.

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* A NEW GLASS IT ONE RIM EVER CHIPS

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Gentlemen: Please send me, without cost or obligation on my part, a free sample of Libbey's tumbler D-135.

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Serving Citrus Fruits

RACHEL MAYHEW

HAVE you had your citrus fruit today? Modern agricultural and transportation methods have made oranges, lemons and grapefruit available in abundance winter and summer, while tangerines and limes are obtainable through a longer season than formerly. For variety and convenience, canned sections and juice, frozen juice and concentrate enlarge our source of supply.

The preparation of citrus fruit for market involves the use of a number of specialized processes, including washing, polishing, grading, sizing, packing, coloring, or "degreening," and refrigeration. Before the fruit can be shipped it must meet the established legal standards of maturity of the state in which it is grown, as well as the regulations of the food and drug administration of the U. S. Department of Agriculture.

Determining Ripeness

The standard requirement for determining ripeness is not color but a ratio of acid to sugar in the proportion of one to eight. Since the consuming market demands that oranges have typical orange color, however, and some varieties of ripe oranges may be green in color, various processes have been developed to provide the normal color desired. Early Washington Navels, because of heavily foliated trees, ripen before they develop an orange color; Valencia oranges "regreen" at the stem end in the spring after the new growth starts and late varieties of grapefruit remain green in the spring. Coloring, or "degreening," is a process of exposing the fruit to ethylene gas, which destroys the green chlorophyl and thereby reveals the orange or yellow pigment without otherwise changing the composition.

This fruit requires no labeling but if artificial coloring is added the fruit must be stamped "color added." In California the treatment is referred to as "sweating," whereas with lemons it is known as "forced curing."

Our supply of citrus fruit is continuous, for as the season is ending in one state it is beginning in another.

California orange varieties are the Navel (seedless), available from November to May, and Valencia (with seeds), from April to November. They are graded as follows: No. 1, fancy, free from blemishes; No. 2, choice, good sound fruit with limited surface imperfections; No. 3, standard, discolored and otherwise imperfect fruit. They are packed in 10 sizes, ranging from 100 to 344, according to the number of fruits in the box.

The Florida season ordinarily begins about October and closes in June or July. The fruit is classed as: Early—Parson Brown, Hamlin; Midseason—Pineapple seedlings, and Late—Valencia. It ranges in nine sizes from 96 to 324 in a box. Usually, a good quality of orange, lemon or grapefruit is firm but not hard; it is not soft enough for the skin to dent when pressed. Navel oranges are preferred for slicing and sectioning and the other varieties, for juice. The quantity of juice from Florida and California oranges depends on the season and the size and type of the fruit.

Florida, Texas, California and Arizona supply grapefruit packed in the standard boxes similar to those used for oranges. Grade designations consist of Brights, with a pale yellow color; Goldens, and Russets. The Florida varieties are seed grapefruit, seedless and pink. Texas varieties are the same with little seed fruit. California and Arizona grow seedless fruit almost exclusively. Only seed fruit can be used in the canning of sections since seedless fruit does not hold together well.

Lemons come from California and Italy, ranging in 7 sizes from 240 to 540. California lemons are packed like oranges in respect to boxes and grades. The Italian type is quite thin skinned. The skin should appear waxy and be a good yellow. The Persian or Tahiti lime is known as the green lime. When it is picked it should be very green in color and slightly soft, with a comparatively smooth skin. Key limes, grown almost entirely on the Florida Keys, have a more distinctive flavor and less juice than the Persian variety. The preferred color for Key limes is yellow. The season for both is from May to October.

Tangerines range in size from 100 to 294 and are packed in half boxes, holding four fifths bushel. They are on the market from November to March.

Packaging Citrus Fruits

Citrus fruits are packed in boxes with nailed tops, the standard Florida box holding 1.6 bushels and the California holding 1.47 bushels. Florida also packs fruit in Bruce boxes, which are wired and hinged instead of nailed. Oranges and grapefruit are often packed in open mesh bags that hold half of a standard box or 40 pounds. These are used chiefly by retail stores. Limes and tangerines are packed in the half boxes; lemons, in standard boxes. There are two kinds of wrappings: entire, in which each fruit is wrapped, and blind pack, in which the top and bottom layers are wrapped. Bruce packed fruit is not wrapped. These differences partially influence the price of the fruit.

The best temperature for short-time storage of citrus fruits is between 45° and 50° F. They should not be stored with eggs or butter.

All citrus fruits are excellent sources of vitamin C and, inasmuch as this vitamin cannot be synthesized from other dietary components, it should be supplied by our daily foods. Vitamin C is unstable and easily destroyed by oxidation. Fresh orange juice loses about 10 per cent of its ascorbic acid if it is left standing in the refrigerator in a covered container for six hours.

Miss Mayhew is assistant dietitian, Roosevelt Hospital, New York City.

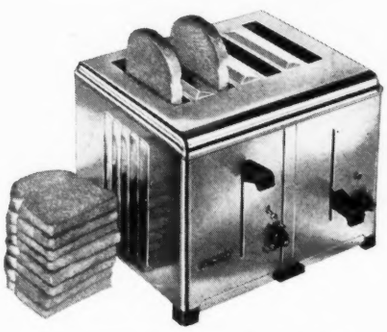
December Menus for the Small Hospital

Estella O. Yaudes
Dietitian, Clearfield Hospital, Clearfield, Pa.

	Breakfast		Luncheon or Supper				
Day	Fruit	Main Dish	Soup or Appetizer	Main Dish	Potatoes or Substitute	Vegetable or Salad	Dessert
1.	Grapefruit	Scrambled Eggs, Raisin Toast	Vegetable Soup	Cold Meat Cuts	Potato Chips	Pineapple and Cheese Salad	Lemon-Cream Rice
2.	Stewed Peaches	Soft Cooked Eggs	Tomato Juice	Baked Macaroni and Cheese	Buttered Rolls	Molded Grapefruit Salad	Emergency Cake
3.	Stewed Apricots and Raisins	Bacon, French Toast	Clam Chowder	Cold Ham	Stuffed Baked Potatoes	Sweet Pickles, Raw Carrot Strips	Royal Ann Cherries
4.	Sliced Bananas	Poached Eggs on Toast	Cream of Tomato Soup	Veal Salad, French Rolls		Pineapple Slaw	Boston Cream Pie
5.	Tomato Juice	Bacon, Pecan Rolls		Beef Patties	Mashed Sweet Potatoes	Buttered Asparagus Tips	Fruit Salad, Whipped Cream Dressing
6.	Orange Juice	Eggs, Toast and Jelly		Salmon Croquettes	Parsley Potatoes	Molded Vegetable Salad	Egg Plums, Cookies
7.	Warm Baked Apple and Cream	Fried Mush, Syrup, Rolls	Veal Noodle Soup	Cold Meat Cuts		Beatrice Salad	Devil's Food Cake, Peaches
8.	Orange Juice	Fried Ham, Rolls, Preserves	Potato Soup	Cold Ham, Hot Rolls		Olives and Celery	Fruit Gelatin, Whipped Cream
9.	Stewed Prunes With Apricots	Bacon, Raisin Toast	Tomato Juice	Hot Meat Loaf	Creamed Potatoes	Beet Relish	Pears, Gingersnaps
10.	Applesauce	Creamed Dried Beef, Toast		Cheese Soufflé	Green Beans	Raw Carrot Strips	Green Gage Plums
11.	Orange Juice	Poached Eggs, Toast		Creamed Asparagus on Toast	Escalloped Corn	Prune and Cheese Salad	Rice Pudding With Raisins
12.	Baked Apple With Cream	Scrambled Ham and Eggs, Rolls		Escalloped Potatoes With Egg and Cheese	Buttered Green Baby Lima Beans	Pineapple Lime Salad	Gingerbread
13.	Tomato Juice	Scrambled Eggs, Hot Rolls	Oyster Soup	Deviled Eggs	Potato Chips	Beatrice Salad	Royal Ann Cherries
14.	Stewed Peaches	Eggs, Rolls, Marmalade	Tomato Juice	Creamed Sweetbreads au Gratin	Baked Potatoes	Pineapple Lime Salad	Rice Flake Cookies
15.	Grapefruit	Bacon, Toasted Coffee Rolls	Cream of Tomato Soup	Toasted Cheese Sandwiches		Fruit Salad, Pickles	Spanish Bun Cake
16.	Bananas	Eggs, Raisin Toast		Cold Ham	Hashed Brown Potatoes	Mixed Vegetable Salad	Cherry Up-Side-Down Cake
17.	Tomato Juice	Fried Ham, Toast, Jelly		Creamed Dried Beef, Hot Biscuits	Parsley Potatoes	Pineapple and Cheese Salad	Emergency Cake
18.	Orange Juice	Bacon, Rolls, Marmalade		Hamburgers on Buns	Creamed Potatoes	Celery Hearts	Apricots
19.	Canned Oranges	Scrambled Eggs, Toast, Jelly		Shepherd's Pie	Peas	Cardinal Salad	Pineapple
20.	Pineapple Juice	Eggs, Cinnamon Buns	Clam Chowder	Baked Stuffed Eggs	Buttered Whole Green String Beans	Fruit Salad	Cookies
21.	Canned Grapefruit	Canadian Bacon, Toast		Chopped Beef Cutlet	Baked Squash	Celery	Red Cherries, Gingersnaps
22.	Baked Apple With Dates	Scrambled Eggs, Toast	Vegetable Soup	Cold Cuts	Potato Salad	Lettuce, Russian Dressing	Fruit Cup
23.	Stewed Apricots	Grilled Ham, Toast	Noodle Soup	Bacon	Buttered Sweet Potatoes	Pineapple Slaw	Riced Gelatin With Whipped Cream
24.	Tomato Juice	Fried Ham and Eggs, Toast		Eggs à la Golden Rod on Toast	Buttered Whole Green Beans	Molded Grapefruit Salad	Cup Cakes
25.	Orange Juice	Bacon, Rolls, Marmalade	Tomato Juice	Turkey Hash	Potato Cakes	Banana-Peanut Salad	Fruit Cake
26.	Stewed Prunes With Apricots	Poached Eggs, Toast	Cream of Tomato Soup	Baked Macaroni and Cheese		Beatrice Salad	Fruited Gelatin
27.	Peeled French Prunes	Scrambled Eggs, Toast, Jelly		Escalloped Corn	Mashed Potatoes	Egg-Beet Salad	Apricot Whip
28.	Baked Apple	Eggs, Raisin Toast	Vegetarian Soup	Veal Salad, Hot Rolls		Sweet Relish	Peaches, Sugar Cookies
29.	Grapefruit	Hard Cooked Eggs, Rolls, Jelly	Pembroke Chicken Soup	Cold Ham	Potato Chips	Golden Salad	Devil's Food Cake
30.	Stewed Peaches	Bacon, Raisin Toast	Tomato Juice	Scrambled Eggs With Mushrooms	Stuffed Baked Potatoes	Quick Coleslaw	Fruit Cup
31.	Applesauce With Raisins	Fried Mush, Syrup, Toast		Baked Hash	String Beans	Waldorf Salad	Gingerbread

Recipes will be supplied on request by The Modern Hospital, Chicago. Space precludes listings of cereals, several varieties of which are always offered for breakfast.

Fresh, hot, "just-like-home" toast is easy with a TOASTMASTER Toaster!



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With Good Will Our Goal

MILDRED L. BURT

ANY industrial concern, though it may carry on its balance sheet a valuation of only $1 for "good will," knows that this intangible something so hard to define is a valuable asset, often worth many thousands of dollars in the actual conduct of its business.

In just the same way, a hospital strives to build good will for itself with the public in its locality. Not only is it the duty but it should be the pleasure of each department to accept its full share in this responsibility and to arrange the conduct of its affairs that it may contribute materially to the building of fine public relations.

Responsible for Cleanliness

The housekeeping department is no exception to this principle and the fact that it has a definite responsibility for cleanliness, as well as for maintenance of furniture and fixtures in the hospital, in no way limits the contribution that it can make.

Rather, the very nature of its work places the department in a position that largely influences the opinions of both the patients, who, after all, are the best press agents a hospital can have, and those who are temporarily within its gates, either as visitors or as prospective patients. Even those who visit the hospital in a business way may be affected by what they see and hear, to the credit or to the detriment of the institution.

The housekeeping department must constantly bear in mind that by thorough, scrupulous cleanliness it can favorably impress the public, within and without.

Constant attention to orderliness will create an atmosphere of harmony and peace that may definitely color public opinion. Furniture and fixtures kept in the prime of condition, even though they are obviously not new, will further maintain the impression so necessary to the creation of a feeling of peace and well-being. Clean floors and walls, shining brasses and fresh draperies are symbols of what the hospital itself stands for in the way of neatness and order.

Personnel Must Take Pride in Work

Porters and maids must be taught to take pride and pleasure in doing their part in maintaining this orderliness. Not only should they be taught to keep their own departments spotlessly clean but they should learn to carry this through the entire hospital by constant alertness for a bit of paper that should be picked up from the floor, a piece of furniture that should be returned to its proper place, a light that should be turned on or off or a window shade or picture that needs straightening. If every member of the housekeeping staff cooperates in this work, the result will be an immaculate hospital.

The appearance of maids and porters is an equally important item in building good will for the hospital. Employes who are seen about the building in the course of their labors should be encouraged to keep themselves as neat as is consistent with the nature of their work. Buttons off garments or torn and soiled garments do not make for confidence in the hospital. The housekeeper herself can be a symbol of what the housekeeping department stands for through her personal appearance.

The responsibilities of the housekeeping department, as far as the general public is concerned, are not at an end with the careful maintenance of the building. It can, to a great degree, contribute to this intangible good will through a consistent practice of courtesy on the part of its members.

Porters and maids who are constantly coming in contact with patients and visitors can help to make or to mar the interest of the public in the institution by their manners, their way of handling complaints and their willingness to go out of their way to be helpful to visitors.

If a porter meets a bewildered visitor in the hall, he should know how to direct him carefully and clearly. Encourage the porter to step a few feet out of his way, if necessary, to make the direction clearer. Certainly, no harm would result if an employe were to take a few steps to a near-by elevator and press the button, telling the inquirer at which floor to leave the elevator and where to get further directions.

Perhaps the visitor will feel that here is something that money cannot buy, something that he finds in this hospital in greater abundance than in other institutions.

Tact and Diplomacy Required

Patients may be irritable or unreasonable and visitors may be hurried or preoccupied, yet employes should take pride in meeting their demands tactfully and making them comfortable in any way that comes within their scope. When true unreasonableness exists, they should be taught to recognize it and to refer the angry patient or visitor to the person who has the authority or ability to handle the particular situation.

The housekeeping department can build up within itself an interest in courtesy and a pride that will enable it, as a department, to take an active part in elevating the hospital to a position of honor and prestige in the local community.

Miss Burt is executive housekeeper, Mountainside Hospital, Montclair, N. J.

Do not confuse KNOX PLAIN *(Sparkling)* GELATINE (U.S.P.) with inferior grades of gelatine or with pre-flavored, sugar-laden dessert powders. Knox Gelatine contains absolutely no sugar or other substances to cause gas or fermentation. It is manufactured with twenty-one laboratory tests, including rigid bacteriological control to maintain purity and quality. Knox Gelatine is dependable for uniformity and strength. Your hospital will procure it for your patients, if you specify Knox by name.

KNOX GELATINE (U.S.P.)	FACTORY-FLAVORED GELATIN DESSERTS
All gelatine.	Only contain 10% to 12% gelatine.
Protein 85% to 87%.	Protein 10% to 12%.
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Absolutely no sugar.	85% sugar average.
No flavoring. No coloring. Odorless. Tasteless. Blends well with practically any food.	Contain flavoring, acid and coloring matter.
Practical for many diets including: diabetic, peptic ulcer, convalescent, anorexic, tubercular, colitic, aged, etc.	Contraindicated in diabetic, peptic ulcer and other diets.

INFANTS IMPROVED *by*

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A lower incidence of vomiting, diarrhea, and constipation resulted from adding 1% and 2% plain, unflavored gelatine to milk fed a group of infants two years ago. An additional advantage was a decrease in the incidence of upper-respiratory infections.

Repetition of this work* has substantiated the results.

PLAIN *(Sparkling)* KNOX GELATINE (U.S.P.) was used in all these studies.

CONVENIENT GELATINE PROPORTIONS:

1% — One envelope to 3 pints or 1 level teaspoon to 18 ounces of milk.

2% — One envelope to 1½ pints or 1 level teaspoon to 9 ounces of milk.

(Formula Sent Upon Request)

KNOX GELATINE

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NEUTRAL—NO SUGAR

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* Further Clinical Observations on Feeding Infants Whole Milk, Gelatinized Milk, and Acidified Milk, C. LORING JOSLIN, M.D., F.A.A.P.; Bulletin of the School of Medicine, University of Maryland; Jan. 1939.

KNOX GELATINE, Johnstown, New York, Dept. 465.

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War Declared on Pests!

MABEL AGNES BAILIE

The behavior problems of the moth family are so numerous that Miss Bailie devotes this installment of her article on pests to it

THE injury done to furniture by moths is confined principally to pieces of furniture that are covered with wool, yet these insects are a decided menace in any institution because the larvae feed on all materials of animal origin, such as hair, fur, wool and feathers. The felt in pianos and the woolen lint lodged in floor cracks, behind baseboards or carried by air currents into inaccessible places in partitions provide food for them. Moths do not feed upon materials of vegetable origin. Linen, cotton, rayon, wrapping paper and vegetable fibers will not be injured by them although in rare instances the moth larvae have been known to eat holes in paper or in cotton in order to obtain bits of material to build into the cocoon.

The female moth, seeking a dark secluded place, may crawl between the cushions and the back or the sides of a chair or divan. In these spaces or among the springs she finds a satisfactory place in which to lay her eggs unseen and unmolested by brush or vacuum cleaner. As a rule, however, the female moth deposits her eggs here and there on the cover. A few days later they begin to hatch and the larvae squeeze through incredibly small holes in order to get away from the light, thus secreting themselves in the fabric, which they later use for food.

While it is doubtful whether any woolen fabrics can be rendered permanently mothproof, it has been demonstrated that fabrics so treated offer high resistance to moth infestation. There are many excellent ways for freeing all kinds of furnishings of moths.

Most important in eliminating the development of surface feeding are frequent brushing and thorough treatment with the vacuum cleaner. If furniture covers are not mothproofed they should be thoroughly gone over by one of these methods at least once a week to dislodge and crush eggs and to kill the larvae.

Fumigation consists of subjecting furniture, enclosed in tight rooms or vaults, to gasses or vapors that penetrate the upholstering and kill all forms of moth life, including the destruction of the eggs. The fumigants most commonly used are carbon disulphite, ethylene dichloricide —carbon tetrachloride mixture, ethylene oxide alone or in combination with carbon dioxide, naphthalene and paradichlorobenzene. Each of these fumigants has some advantages, and which fumigant is best to use will depend upon circumstances. Carbon disulphite, while effective, is explosive and inflammable in the presence of fire in any form and should be used with great care.

Paradichlorobenzene, or dichloricide, is a white crystalline chemical similar in general appearance to naphthalene. If the crystals are finely divided and scattered by hand over the furniture cover; down around the cushions, especially where the cushions touch the arms or backs of the furniture, and even down into the spaces at the side and back, they evaporate, forming a gas or vapor that is heavier than air. If the vapor can be confined within the piece of furniture long enough and in sufficient concentration, all stages of moths will be killed. To ensure the necessary concentration 2 or 3 pounds of the crystals should be well distributed over the cover of the chair and the furniture immediately wrapped in several old blankets that overlap each other well and more than touch the floor on all sides. Instead of blankets, large rubberized bags or shellacked cartons can be used. If furniture is allowed to stand thus treated and wrapped during warm weather, all of the moths will be killed.

Inasmuch as the other fumigants mentioned can be used in the same manner it will not be necessary to discuss them further except to state that great care must be exercised in the use of carbon disulphite on account of the fire hazard.

Placing furniture outdoors in zero weather will kill all the moths within a few hours after the zero temperature reaches the individual moths. The unfortunate feature of this otherwise excellent control method is that zero weather is seldom available at the right time and place. It is always a good practice, however, to expose upholstered furniture to cold whenever possible and such exposures should be made two or three times during the winter.

There are on the market a number of sprays, consisting of light mineral oils with or without a small percentage of pyrethrum, that deserve consideration in eradicating moth infestation from upholstered furniture. The vapor of the fumigants penetrates and kills the moths when it reaches them in proper concentration. Mothproofing preparations are of value in proportion to the moth resistance they impart to the treated fabric but these so-called "contact sprays" must actually reach and spread over the bodies of the moth and the egg, worm and pupa stages if they are to be effective. They are called contact sprays because their effectiveness depends upon being brought into contact with the insect itself. They are of no practical value if sprayed lightly over the furniture.

Infestation in the pile of mohair and other covers can easily be killed out by spraying the furniture with an oil spray. This oil spray, however, cannot be depended upon to reach the moths beneath the cover. A good moth spray can be made by mixing 1 quart of water-white oil (triple refined kerosene); 2 ounces of No. 20 pyrethrum, and 2 ounces of carbon tetrachloride.

Miss Bailie is resident director, Rockford College, Rockford, Ill.

ANNOUNCING

NEW *Improved* RY-KRISP

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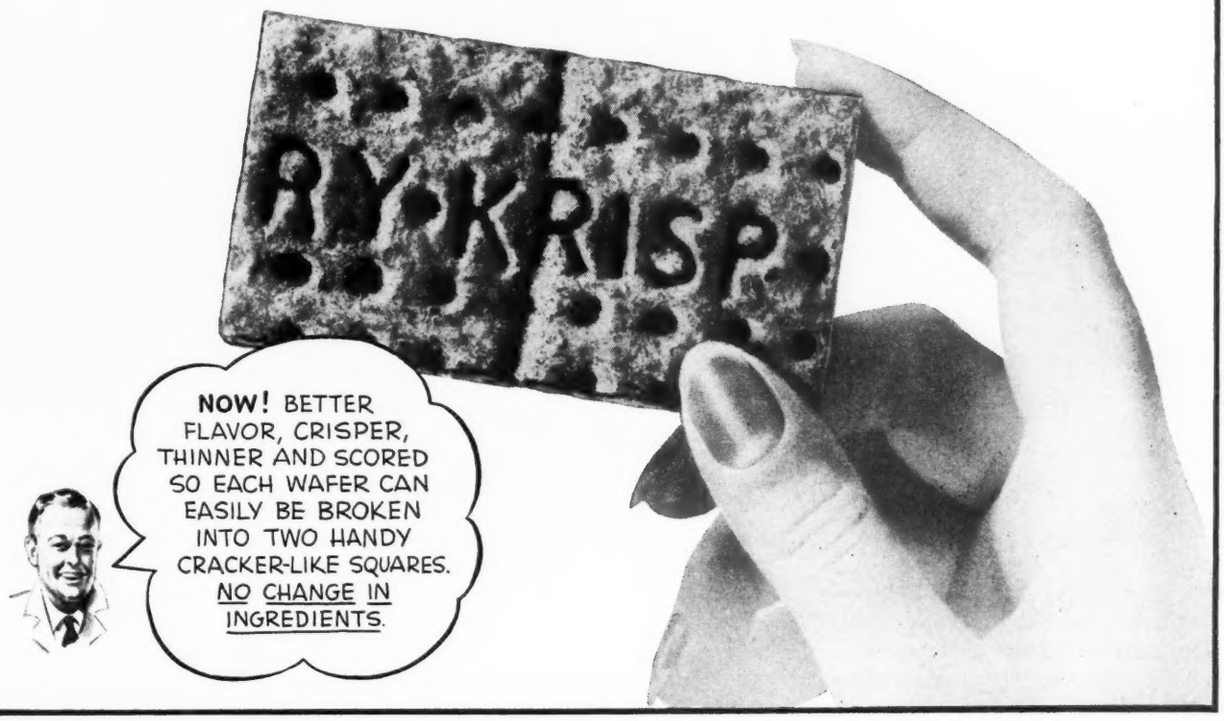
Solves 3 diet problems for hospitals



1. IN ALLERGY DIETS

Ry-Krisp is a safe bread for patients allergic to wheat, milk or eggs... because it is made simply of pure whole rye, water and salt. When rolled, ground, or crumbled and used as flour, Ry-Krisp is also a safe ingredient in preparing many tempting wheat-free dishes.

2. IN LOW-CALORIE DIETS

Ry-Krisp is indicated in reducing diets because it is an unleavened bread, and each wafer yields only 20 calories. Ry-Krisp is an economical source of energy, provides bulk to help stimulate natural elimination and each 6-gram wafer furnishes 6 International Units vitamin B_1.

3. IN NORMAL DIETS

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Low-Calorie Diets — 1700 calories for men, 1200 for women. Give wide choice of foods. No special cooking. Allow safe weight loss of about ¼ pound a day. Supply all needed minerals and vitamins with possible exception of vitamin D.

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Hospital Pharmacy

Nurses Can Learn From Pharmacist

LOUIS M. SCHEINESON

IF one were to draw a diagram of the respective branches of the medical science in their proper sequence, pharmacy and nursing would be placed beside each other.

We have learned today that the nurse is indispensable to the physician and to the pharmacist, as well as to her patient. It is incorrect to believe that the relationship between the physician and nurse is that of master and servant. Rather, it is that of two partners employed in a common undertaking, *i.e.* the improvement in health of the patients under their care. The accomplishment of this common undertaking requires the intelligent application on the part of the nurse of the medicines prescribed by the physician. The nurse has the responsibility of administering the medicines and must, therefore, learn the fundamental principles of drug therapy if she is to carry out her duties intelligently.

Upon the successful completion of her training, the nurse is called upon to exercise great skill in preparing and in administering drugs. Many details of treatment are often left to her discretion. In many instances, the administration of drugs in an emergency is also left to her judgment. It is difficult to enumerate the specific tasks with which the nurse is confronted in the course of her professional activities.

Pharmacy's Part in Nursing

The department that prepares the medicines and procures the material with which to treat diseases can and should play an important rôle in successful bedside nursing. For efficient performance the nurse must be familiar with pharmaceutical arithmetic. It is necessary for her to be acquainted with both the metric and the apothecaries' system of weights and measures, as well as with household measures. She will be required to make dilutions from concentrations and to transpose the dosage from one system of weights and measures to the other. In the pharmacy department, the nurse familiarizes herself with the technical terminology of the medical profession, the terms that are most frequently used by the physician, such as Latin and English abbreviations and symbols, and, most important, the drug or medicine itself. The nurse familiarizes herself with its odor, taste and appearance. It is essential that she be acquainted with its action and limitations, as well as with the ingredients with which it may be combined.

Mr. Scheineson is the pharmacist at Jewish Hospital, Cincinnati.

Bureau of Information

The nurse should find the pharmacy an interesting place. While waiting for her prescription to be compounded, she should study her environment, the beautifully colored chemicals, the crude drugs and the finished products. The technic and the agility with which the pharmacist works can also be observed. The pharmacist's dexterity is like that of the artist. When the nurse realizes this, she will conclude that this is one of the most important and interesting departments in the hospital.

The pharmacy is not only a dispensary of drugs but a bureau of information as well. The nurse can obtain a postgraduate course in materia medica by asking questions of the pharmacist.

New drugs, such as sulfanilamide, sulfapyridine and sulfathiazole, are confusing. The nurse must be acquainted with the toxic signs and symptoms from an overdose. She must know that klotogen, thyloquinone and vitamin K are synonymous and the method of administration. While the physician informs the nurse of the most important phases in administering these products, a brochure describing them is kept on file in the hospital pharmacy. These brochures are readily available for reference and a study of them tends to crystallize the instructions given by the physician.

The graduate nurse cannot depend upon the textbooks that she studied ten years ago, two years ago or, in some instances, only last year to keep her abreast of new therapeutic agents. For a knowledge of these the pharmacy should be her textbook.

The friendly relationship between the pharmacist and the nurse is as important as the relationship between the nurse and the physician. The pharmacist is there to serve all those who need him, and a cooperative spirit should always exist between him and the other department heads of the hospital.

How Nurse Can Help Pharmacist

Cooperation between the nursing department and the pharmacy is of particular importance. What the pharmacist can do for the nurse is counterbalanced by what she can do for him. The nurse should always remember that the pharmacist has other responsible duties to perform. The time element is an important factor. Therefore, requisitions and prescriptions must be received by his department immediately. If the nurse allows these items to accumulate she makes his position difficult both for himself and for the institution that he serves. When requisitions and prescriptions are sent to him at the last possible moment, he is rushed to such an extent that the medicines do not receive his full at-

tention. This can prove disastrous to the patient, as well as to the pharmacist himself.

Another way to establish a friendly relationship with the pharmacist is to replenish the various stock items before the floor supply is consumed. Last minute rush orders should be the exception rather than the rule. Rush orders should be sent to the pharmacy in cases of emergency only when demands have reached unprecedented peaks.

Thus, one can readily realize the importance of an alliance between these two departments. Only when the pharmacy and the nursing department cooperate can the smooth functioning that is so necessary to hospital service be attained.

Featuring Fountain Service

FRANK R. BRADLEY, M.D.

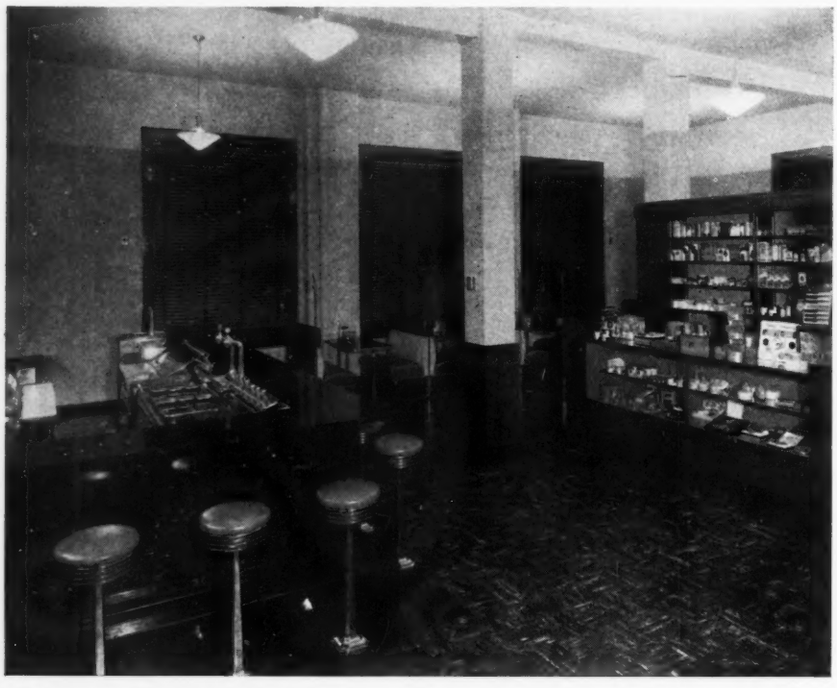
THE fountain service, which was installed in the modernized pharmacy at Barnes Hospital, St. Louis, has proved to be extremely popular with patients, visitors and the hospital's personnel.

The compact 12 stool soda fountain and arrangement of eight booths seating four persons each are managed by the fountain boy under the direction of the chief pharmacist. The fountain boy consults with the chief dietitian from time to time concerning his menus and the preparation and cooking done for the food service by the main kitchen.

The food is prepared in three places. The main kitchen prepares and delivers vegetables, fruit juices, milk, ice cream, cold meats, some of the fountain specials and French dressing; cooks roasts and gravies of all kinds, and bakes pastries. Fresh vegetables are prepared on a hot plate in a small room just under the fountain. A small dumb-waiter operated by hand is used to send the food up as it is ordered. An electric griddle is utilized for frying hamburgers, bacon, pork chops, veal steaks, beef steaks, pork tenderloin, pork sausage, sausage links, as well as ham and eggs. There are also a battery of coffee makers, two waffle irons, a toaster and other customary equipment for the typical soda fountain. Soiled dishes are washed in the room to the rear of the back bar in a small electrical dishwasher with a steam spray attachment.

Sample menus of food served and prices are given below:

Doctor Bradley is superintendent of Barnes Hospital, St. Louis.



The new fountain service of the modernized pharmacy at Barnes Hospital is equipped with griddles, coffee makers, waffle irons and toasters.

Breakfast

Choice of dry cereal with
Half and half *10c*
Cream *15c*
Orange juice *10c*
Tomato juice *10c*
Pineapple juice *10c*

Rolls *5c*
Buttered toast *5c*
Doughnuts (2) *5c*
Waffle *10c*
Waffle and bacon or link sausage *20c*
Coffee *5c*
Tea *5c*
Hot chocolate *10c*
Milk *5c*

Luncheons

30c Pork Sausage 30c

Pork sausage with sliced pineapple, mashed potatoes and gravy, lima beans, luncheon roll and butter, coffee, tea or milk.

25c Frankfurters and Sauerkraut 25c

Frankfurters and sauerkraut, mashed potatoes and gravy, luncheon roll and butter, coffee, tea or milk.

25c Vegetable Plate 25c

Lima beans, mashed potatoes, sauerkraut, pineapple slices, luncheon roll and butter, coffee, tea or milk.

25c Hot Roast Beef 25c

Hot roast beef, mashed potatoes and gravy, coffee, tea or milk.

Sandwiches

Pork sausage on bun *10c*
Frankfurter on bun *10c*
Hamburger on bun *10c*
Baked ham *15c*
Hot roast beef *15c*
Ham and cheese combination *20c*
Ham salad on toast *15c*

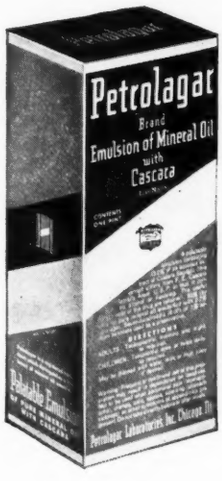
Suggestions

Frankfurter on bun, pineapple sundae, coffee *25c*
Hot roast beef sandwich and malted milk *25c*
Pork sausage sandwich, pie à la mode, Coca Cola *30c*
Baked ham, American cheese and tomato sandwich, large Coca Cola *30c*

Pie ..... *10c* *Sodas* *15c*
Pie à la mode 15c *Sundaes* *15c*

For Stubborn Cases...

Petrolagar* with Cascara



Stubborn cases of constipation usually yield to Petrolagar with Cascara.

This preparation provides sufficient laxative effect to help restore normal bowel habit in chronic cases, yet it is mild enough for use in obstetrical cases. Each tablespoonful contains 13.2% of non-bitter aqueous extract of Cascara Sagrada.

The dose of Petrolagar with Cascara is one tablespoonful two to three times daily—gradually diminished. It has the advantage of exceptional palatability and continued effectiveness despite prolonged use.

Petrolagar with Cascara is available in 16 ounce bottles at all pharmacies and in the special Hospital Dispensing Unit at hospitals.

**Petrolagar—The trademark of Petrolagar Laboratories, Inc., for its brand of mineral oil emulsion—liquid petrolatum 65 cc. emulsified with 0.7 Gm. agar in a menstruum to make 100 cc.*

Petrolagar Laboratories, Inc. • 8134 McCormick Boulevard • Chicago, Illinois

NOTES AND ABSTRACTS

Conducted by Carl C. Pfeiffer, M.D., F. F. Yonkman, M.D., Arnold J. Lehman, M.D., and Harold Chase, M.D., Wayne University, Detroit.

Error Corrected

• In the July column it was stated that alpha-lobeline should only be given subcutaneously. We have since been informed that the purified lobelin can be given intravenously.

Bile Salt Therapy

• Ivy and Berman of Northwestern University have recently summarized the physiology of bile salt therapy and have indicated the rationale of such treatment in biliary disease. The bile salts promote the formation of bile, solubilize fatty acids, aid in the digestion and absorption of fat, facilitate the absorption of both calcium and iron, have a laxative action and have an important rôle in detoxifying bacterial toxins in the gastro-intestinal tract.

During the secretion of bile salts the liver glycogen is diminished. Giving bile salts also favorably influences the ratio of bile salts to cholesterol. In the absence of bile salts in the intestine the oral administration of bile salts is indicated to improve digestion and absorption. The rôle of bile salts in the absorption of vitamins D and K and fats is alone a sufficient indication.

The presence of bile pigment in the feces does not necessarily indicate that bile salts are being secreted in the bile. The liver may excrete pigment when it does not form and secrete bile salts. Frequently, in biliary tract disease, in the absence of total obstruction, sufficient hepatitis may be present to diminish bile salt synthesis markedly but not to prevent bile pigment excretion. In biliary tract disease without acute hepatitis, bile salts should be administered to flush the biliary passages with a copious flow of low viscosity.

Bile salts can be used with the hope of counteracting a tendency toward stasis and its effects and in this way produce and maintain a copious flow of bile through the biliary passages. However, to obtain this effect the patient must have an active liver that will secrete bile salts. A brisk flow of fluid through the hepatic ducts tends to prevent ascending infection. Inasmuch as bile salts are laxative, a lack of bile salts would increase the tendency toward constipation and the increase in constipation would further affect the liver and Oddi's sphincter, thus possibly setting up a vicious circle that is broken best by the oral administration of bile salts.

To what extent the administration of bile salts will change the chemistry of the bile in the gallbladder and will flush out the gallbladder is uncertain. It is possible that a washing out of the gallbladder might be obtained by giving bile salts and then fat to empty the gallbladder, repeating the procedure three or four times a day. The authors doubt the wisdom of bile salt therapy in the presence of biliary tract disease and acute hepatitis except for the purpose of improving intestinal absorption.

Skin Penetration by Fats

• Elles and Wolff, working in New York City, have recently published a careful study of the penetration of the skin by animal, vegetable and mineral fats. Since no definite technic has been evolved for the determination of fat penetration, the authors made a preliminary study of several methods in order to determine the best procedure to be adopted for subsequent experiments. Certain factors were uniform in all methods. Mature albino rabbits were used, the hair being removed from both control and treated areas with electric clippers. The materials were applied to the skin by daubing with a pad of saturated cotton, light finger massage or spraying. The more viscous products were applied in their normal state and also after being liquefied by gentle heating.

A preliminary series of biopsy specimens was taken one, two, three, four, five, six, seven, eight, sixteen and twenty-four hours after application of the products; normal specimens were always taken from each animal for comparison. Before the biopsy specimens were taken, the areas were swabbed with 70 per cent alcohol and immediately patted dry with cotton. The procedure eliminated an excess of fat on the surface of the skin, thus permitting a more accurate reading of the slides. Sudan III and sudan IV were used for the staining of the fat tissue. However, after preliminary studies sudan IV was adopted as the more clearly defined stain.

The authors describe the various technics used for the determination of fat penetration and discuss and criticize each one. They tested the rate and depth of penetration of six fats.

From their experiments it appears that: (1) fats permeate the skin, in a large measure along the hair shafts and into the oil gland ducts; (2) liquid fats permeate the skin more rapidly than solid fats; (3) animal fats show the greatest depth of penetration, with vegetable fats next and with mineral fats least; (4) most of the fats show optimal penetration between four and six hours after application. After six hours the quantity of fat in the deeper tissues appears to diminish. These factors may well be taken into consideration in the more scientific application of ointments for the greatest pharmacological effect.

Paredrinol

• Weiss and his associates in Boston have been making a thorough study of circulatory collapse induced by sodium nitrite given intravenously to the human subject. The subject or patient shows no sign of collapse while in the prone position but, as soon as the head is raised, collapse leading to syncope occurs. From studies on normal subjects they found that paredrinol (N-dimethyl-p-hydroxyphenethyl amine) was effective in preventing the "venous pooling" present during this syncope.

In four of the subjects the intramuscular injection of 25 mgm. of paredrinol prevented the collapse induced in the upright position by sodium nitrite. In three others it had no effect. In two subjects with severe postural hypotension, symptoms of cerebral anoxia were prevented by the use of paredrinol. In seven of 10 subjects in severe clinical shock resulting from infectious disease, the intramuscular or intravenous injection of from 15 to 50 mgm. of paredrinol caused a rise in arterial pressure. Only two of these subjects showed definite clinical improvement.

The responses of the patients in severe clinical collapse differed from those in the normal subject as follows: (1) from two to four times the amount of paredrinol was required to cause a significant elevation of blood pressure and even then the arterial pressure rarely increased to hypertensive levels; (2) the cardiac rate was usually increased instead of decreased, and (3) repeated doses of the drug, when given after the blood pressure had returned to normal, failed to be as effective as the original injection.

The scientists decided that paredrinol is a useful drug in the treatment of collapse caused by the pooling of blood within a dilated venous system. Their study suggests, however, that in shock resulting primarily from loss of fluid from the blood stream the drug may not be helpful and it may even be harmful.—Carl C. Pfeiffer, M.D.

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News in Review

Ontario Hospital Association Adopts Low Cost Group Hospitalization Plan

A low cost hospital service plan was presented and adopted by the Ontario Hospital Association at its 17th annual convention held in Toronto on October 9 to 11.

The plan, which was described by C. Rufus Rorem as one that was "alert to the needs of the low income groups," would provide 21 days of hospital care and the necessary special services at two different levels. The "standard" plan would give service in wards for $12 per family per year ($6 for an individual), while the semiprivate plan would have annual fees of $9 and $18 for the individual and family, respectively.

The association voted to appropriate $15,000 of its own funds to serve as initial working capital for the organization. Various legal steps must now be taken before the plan can be actually set in motion. A committee of the association, under the chairmanship of R. Fraser Armstrong of the Kingston General Hospital, Kingston, has been at work on the program for several years.

In his luncheon address on October 9, Mr. Rorem stated that more hospital service plans have experienced financial difficulties by charging too much than by charging too little. "A low rate attracts a larger and more representative group of subscribers," Mr. Rorem added.

In discussing the entrance of plans into rural areas he pointed out that the fear sometimes expressed that patients from the small towns would flock into the larger cities if they had hospital service insurance has proved in practice to be unfounded. "Apparently, residents of small towns do not go to the centers in any larger numbers when they have protection than they do without it. The choice of a hospital is usually made with the advice and approval of the family physician," he added.

Mr. Rorem expressed strong desire to have hospital care insurance remain in the hands of nongovernmental organizations. "The government," he said, "can unite the people on routine and nonpersonal matters but personal values are lost when the government attempts to provide this kind of service. The patient's individuality can be given more consideration by voluntary, nongovernmetal agencies that perform a public service but do so under private guidance."

Several hundred hospital administrators, nurses and records librarians attended the sessions of the association held in the Royal York Hotel. There was a large exhibit. The Women's Hospital Aids Association, the Association of Record Librarians of Ontario and the Ontario Association of Medical Social Workers met jointly with the hospital group.

Committee on Health and Medicine Is Appointed to Advise Council on Defense

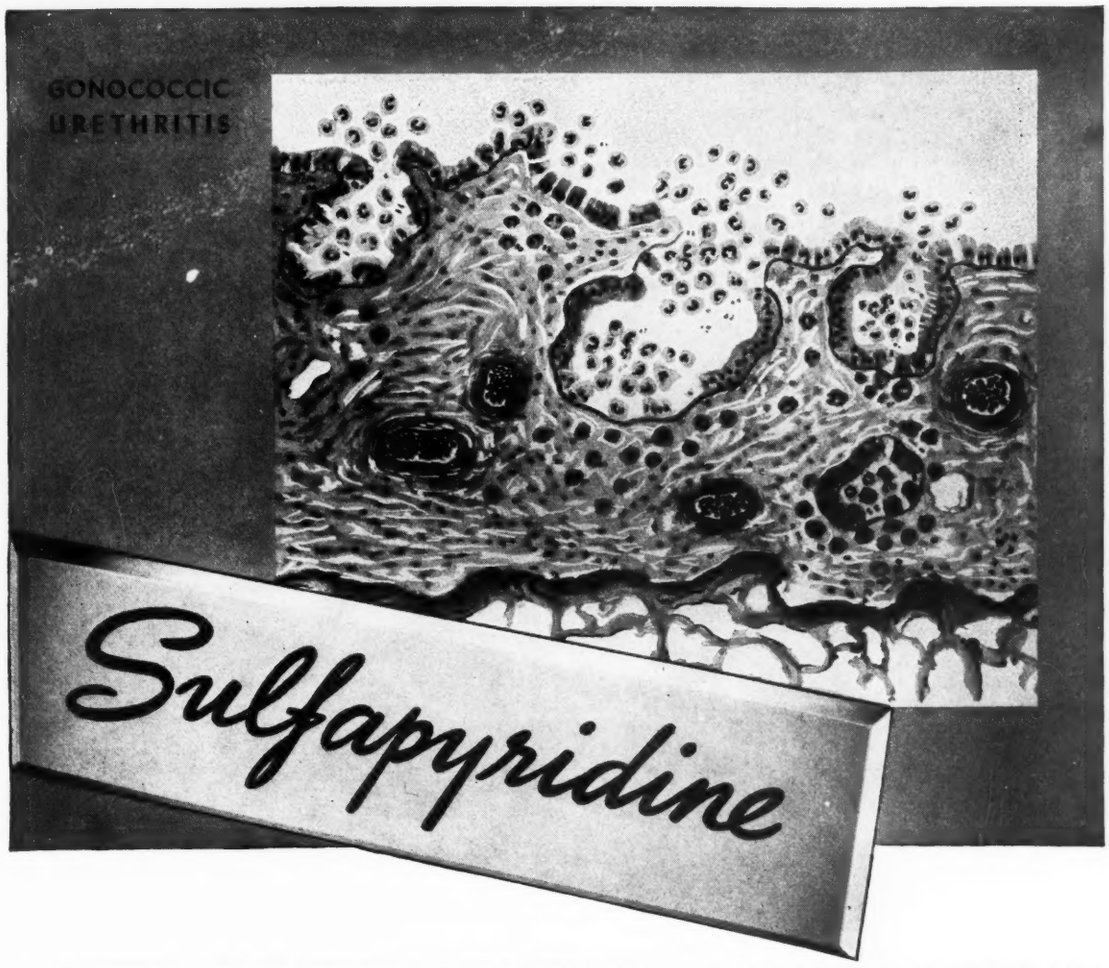
President Roosevelt has appointed a health and medical committee to advise the Council on National Defense and to coordinate health and medical activities affecting the national defense. Dr. Irvin Abell is chairman of this new committee, as well as being chairman of the American Medical Association's committee on medical preparedness. The other members appointed by the President are the surgeons general of the Army, the Navy and the Public Health Service and Dr. Lewis Weed, chairman of the division of medical sciences of the National Research Council, Washington, D. C. The members serve without compensation, except traveling expenses.

The committee is authorized to utilize the laboratories, equipment and services of the medical departments of the Army, Navy, Public Health Service and other institutions as may be needed and, "within the limits of the appropriations allocated to it, to contract with and transfer funds to such institutions and enter into contracts and agreements with individuals or educational or scientific institutions for studies, experimental investigations and reports."

The formation of this committee was undertaken instead of the appointment of a medical coordinator as suggested earlier by Dr. Thomas Parran, surgeon general of the U. S. Public Health Service.

A.H.A. Attendance Figures

Final tabulations on attendance at the Boston convention show that there were more than 4500 registrations, not including the 344 persons who registered for the A.C.H.A. The A.H.A. registration was 2973; nurse anesthetists, 173; occupational therapists, 497. In addition, 865 exhibitors were registered.



A POTENT THERAPEUTIC WEAPON IN GONOCOCCIC INFECTIONS

Clinical studies have demonstrated that sulfapyridine is a valuable chemotherapeutic agent in gonorrhea, and have indicated that it may be more effective than sulfanilamide in the treatment of this condition.

The majority of patients with gonococcic urethritis treated with sulfapyridine experience a rapid subsidence of clinical signs and symptoms. Within a few days after the institution of sulfapyridine therapy, smears and cultures become negative for gonococci, the urine becomes clear, and urethral discharge ceases.

Thus it seems apparent that in sulfapyridine the physician has at his command a potent therapeutic weapon for combating this widespread and distressing disease.

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Literature on request

MERCK & CO. Inc. *Manufacturing Chemists* RAHWAY, N. J.

Urgent Need for Nurses in Federal Health Service Revealed by Civil Service

Urgent need for additional nurses in the federal health service is indicated by a recent announcement from the United States Civil Service Commission that the commission is accepting until further notice applications for the examination of junior graduate nurse, with a base entrance salary of $1620 a year. "This examination will be used to fill a considerable number of vacancies in the U. S. Public Health Service, the Veterans' Administration, some positions in the Indian Service and possibly some in other federal agencies," according to information provided by William C. Hull, executive assistant.

"Nurses who receive appointment as junior graduate nurse are given opportunity to receive excellent postgraduate hospital training," the commission states in a recent pamphlet. "Practically all appointments to the Veterans' Administration hospitals are made at this grade. Junior graduate nurses are given one year's in-service training after appointment to the veterans' facilities. After this period, nurses may be promoted to existing vacancies in higher positions."

During the last five years an average of almost 600 nurses each year has been appointed to the classified service. With the exception of the Army and Navy Nurse Corps, which select their nurses as commissioned personnel with an entrance rank of second lieutenant, there are few nurses' positions in the federal government that are not filled through these civil service examinations.

Full information may be obtained by writing to the U. S. Civil Service Commission, Washington, D. C., or from the board of U. S. Civil Service Examiners in the post office or customhouse of any city with a first or second-class post office. Written tests will be given at approximately three month intervals until the needs of the services have been met.

New Army Hospitals to Be Built in New Orleans, Georgia

New Army hospitals are to be built in New Orleans, Savannah, Ga., and Hinesville, Ga., under the defense appropriation bill. The $1,200,000 cantonment hospital in New Orleans will have a capacity of 1000 beds and will be of the pavilion type, probably of temporary construction. It will be located in the New Orleans lake shore development along Lake Pontchartrain, according to present plans, and will be used to give treatment to men stationed at Camp Beauregard and other army establishments in that section of the country.

A hospital of from 150 to 200 beds has been approved for the airport in Savannah to provide for the 3500 officers and men of the air corps stationed there. For the Savannah anti-aircraft area with six regiments, or about 15,000 men, an institution of from 600 to 800 beds will be constructed at Hinesville.

The hospitals to be built in Georgia are expected to be replaced later by more substantial structures inasmuch as the Savannah and Savannah Area Army bases will be permanent.

Larsen Heads Fund Drive

Roy E. Larsen, president of Time, Inc., has been named chairman of the annual city-wide campaign conducted by the United Hospital Fund, it was announced by David H. McAlpin Pyle. Dean Sage Jr., attorney, is the vice chairman. About 5000 volunteer workers will be enlisted in the campaign. Only individuals and firms that did not give to the Greater New York Fund in its recent appeal will be asked to contribute.

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Preparation of Voluntary Hospitals for Defense Program Told at A.C.S. Meeting

Ten specific steps to be taken by voluntary and public hospitals in anticipation of possible war were outlined by Everett W. Jones, director of Albany Hospital, Albany, N. Y., in the opening meeting of the hospital standardization conference of the American College of Surgeons in Chicago on October 21.

Mr. Jones' suggestions may be summarized as follows:

1. Study the available supply of technicians of all kinds and, if possible, start training one or two extra technicians.

2. Study ways and means to increase enrollment of student nurses in established schools of nursing.

3. Study ways and means of increasing the use of ward aids.

4. In drawing plans for increasing bed capacities in time of emergency, study carefully the equipment and utility facilities necessary to give adequate acute care with no waste of time or energy of nurses. Sudden expansion means fewer nurses to care for more patients.

5. Hospitals that do not form War Department units should cooperate with county medical societies in preparing lists of physicians available for war duty, keeping in mind that modern aerial warfare results primarily in civilian casualties.

6. Start working immediately with local draft boards to convince them that medical students, interns, residents, laboratory technicians and others of the hospital personnel are essential for duty at home and should be placed on the deferred lists for the draft.

7. Work out with local and state welfare departments and governmental units fair rates of payment for indigent so that the financial resources of the voluntary hospitals will not be depleted and the hospitals thus weakened for the inevitably greater loads that will be placed upon them.

8. Make a careful study of all jobs in the hospital to determine where women or older men can replace younger men lost to the Army or industry.

9. Cooperate with local nursing organizations in listing all inactive nurses living in the community and in working out refresher courses for them.

10. Maintain the mental and physical preparation of the people to assume their proper rôles in the defense program through health propaganda and scientific research.

A session of the college program devoted to convalescent care brought forth many important statements. "Approximately 12 per cent of all acutely ill patients should have convalescent facilities available," according to Dr. William H. Walsh, hospital consultant of Chicago.

"Any convalescent center, wherever located, should be an integral part of its parent hospital, so that the care of the patient is continuously under the same medical regime, from the time of his entrance into the city hospital on through the period of convalescence in the country home," declared Dr. Newell C. Gilbert, professor of medicine of Northwestern University, Chicago.

A total of 2806 hospitals were on the approved list of the college as announced by Dr. Irvin Abell of Louisville, Ky., chairman of the board of regents.

Nebraska Joins Mid-West Group

At a special meeting held in Boston during the American Hospital Association convention, the Mid-West Hospital Association voted to admit the Nebraska Hospital Assembly to membership. The association will henceforth be comprised of six states: Arkansas, Colorado, Kansas, Missouri, Nebraska and Oklahoma.

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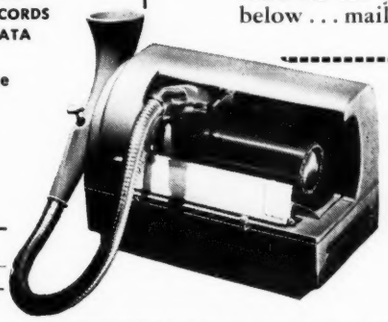

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California and Western Hospital Groups to Hold Mid-Season Meetings

Members of the Association of California Hospitals will hold their mid-year meeting, November 9 and 10, in Fresno. The first day's speakers will include Raymond D. Brisbane, superintendent, Sutter Hospital, Sacramento, whose subject will be "Should Hospitals Be Inspected and Licensed Under State Law?"; Ritz E. Heerman, superintendent, California Hospital, Los Angeles, speaking on "A Proposed Lien Law," and Howard Burrell, attorney for the association, who will discuss the exemption of hospitals from liability arising from negligent acts of employes.

The Sunday session will be devoted to various nursing problems. Stella M. Friedinger, R.N., assistant director of the California State Nurses' Association, will tell what the association is doing to meet the existing shortage of nurses, and Jean Barthe of the association's placement committee will give reasons why hospitals face difficulties in obtaining general duty nurses.

Other nursing problems that are to be discussed at a general round table session are as follows: Should hospitals employ nursing aids to supplement the nursing service; what are the reasons for the increasing difficulty of small hospitals in obtaining adequate registered nurse personnel, and what is considered the minimum standard of wages and employment conditions for nurses?

The fall meeting of the Association of Western Hospitals' public health section will be held in San Jose, Calif., on November 12. The principal topic for discussion will be aspects of the care of psychiatric patients in county institutions. The problem of care of the psychiatric patient prior to commitment will occupy the attention of delegates at the morning session.

The speakers will include Anthony Brazil, district attorney for Monterey County, talking on "The Legal Requirements Affecting the County Hospital in the Handling of the Psychiatric Patient"; Dr. John C. Sharp, medical director, Monterey County Hospital, discussing "Type of Care Necessary to Be Given for the Minimum Period," and Lionel Browne, former deputy attorney general, San Francisco, who will speak on "Length of Time Which a Patient May Be Committed to a County Hospital for Care."

In the afternoon, round tables will be conducted on the care of the nonresident and on malpractice insurance for county hospitals.

U.S.P.H.S. Issues List of Diagnosis Categories

A list of diagnosis categories especially adapted to the tabulation of data on the causes of morbidity in hospitals has been released by the United States Public Health Service. William L. Austin, director of the Bureau of the Census, and Surgeon General Thomas Parran of the public health service in a joint statement outlined a new three digit system to be used for coding purposes. The first two digits denote general categories of illness, while the third separates them into specific diseases or disease sites. Preparation of an alphabetical index of medical terms to assist in assigning diagnoses to the proper categories is under way.

When this work is completed the code and index will be given a trial of several months in a number of hospitals.

Health Pamphlets Issued

Five new and revised pamphlets have been released by the Metropolitan Life Insurance Company, New York City, to be issued to social and health agencies and other professional groups for use with health programs. The booklets are entitled: "Home Safety Quiz," "Rheumatism," "Appendicitis," "Three Meals a Day" and "A Message of Hope About Cancer."

Pittsburgh Plan Offers Protection to Men Called Up for Military Service

Subscribers enrolled in the group hospitalization plan of western Pennsylvania who are called for military service will not lose their membership in the plan, it has been announced by the Hospital Service Association of Pittsburgh. The plan has drawn up regulations to cover not only the subscribers who are drafted but also their wives and families.

The contracts of men having protection for themselves only who are called for military duty will be held in suspense with no payments required during the period of enlistment. At the conclusion of their service these men will have sixty days in which to apply for resumption of coverage under their contracts.

When a married man who holds a contract covering both husband and wife embarks upon military service, the protection will remain in force for the wife and the payment will be reduced to the individual coverage rate. When a family contract is held and only two members of the family, such as a wife and child, remain, the rate will be reduced to the amount usually charged for husband and wife only. When three or more persons remain in the family group for protection while the husband is in military service, the family rate will prevail.

In all cases the husband will have the right to apply for resumption of coverage upon completion of his military service.

Courses in Military Medicine Offered

Almost half of the student body of Cornell University Medical College, New York, has elected to take training in military medicine. Of the 274 male students, 113 are taking military training and will be eligible upon graduation for commissions as first lieutenants in the medical reserve corps. The special courses will cover the principles of military science, first aid, treatment of war wounds, camp and field sanitation and preventive medicine as it relates to the diseases common to armies.

History of Record Librarians

A booklet tracing the organization and growth of the American Association of Medical Record Librarians was prepared by the association for distribution at the annual convention in Chicago, October 21 to 25. The purpose of the organization, its growth and educational activities, together with a list of approved training schools for medical record librarians and the requirements for registration, are set forth in the handbook.

L. H. Burlingham Elected Honorary Life Member of Missouri Hospital Group

The two day meeting of the Missouri Hospital Association was held at Joplin, October 16 and 17. L. C. Austin, administrator, Menorah Hospital, Kansas City, and president-elect of the association, presented a series of charts describing the organization of a hospital and defining the duties of employes in the business and professional departments.

A symposium on hospital legislation was conducted by H. J. Mohler, president of the Missouri Pacific Hospital, St. Louis. Mr. Mohler outlined plans for the lien law which, it is hoped, will be passed by the state legislature during 1941.

At the business session on Thursday morning it was voted to elect Dr. Louis H. Burlingham, former administrator of Barnes Hospital, St. Louis, an honorary life member of the association.

New officers elected, in addition to Mr. Austin as president-elect, include Mrs. Josephine Yates Tisdell, Freeman Hospital, Joplin, first vice president; Sister Alphonsine, DePaul Hospital, St. Louis, second vice president, and Laura A. Hornback, Pike County Hospital, Louisiana, treasurer.

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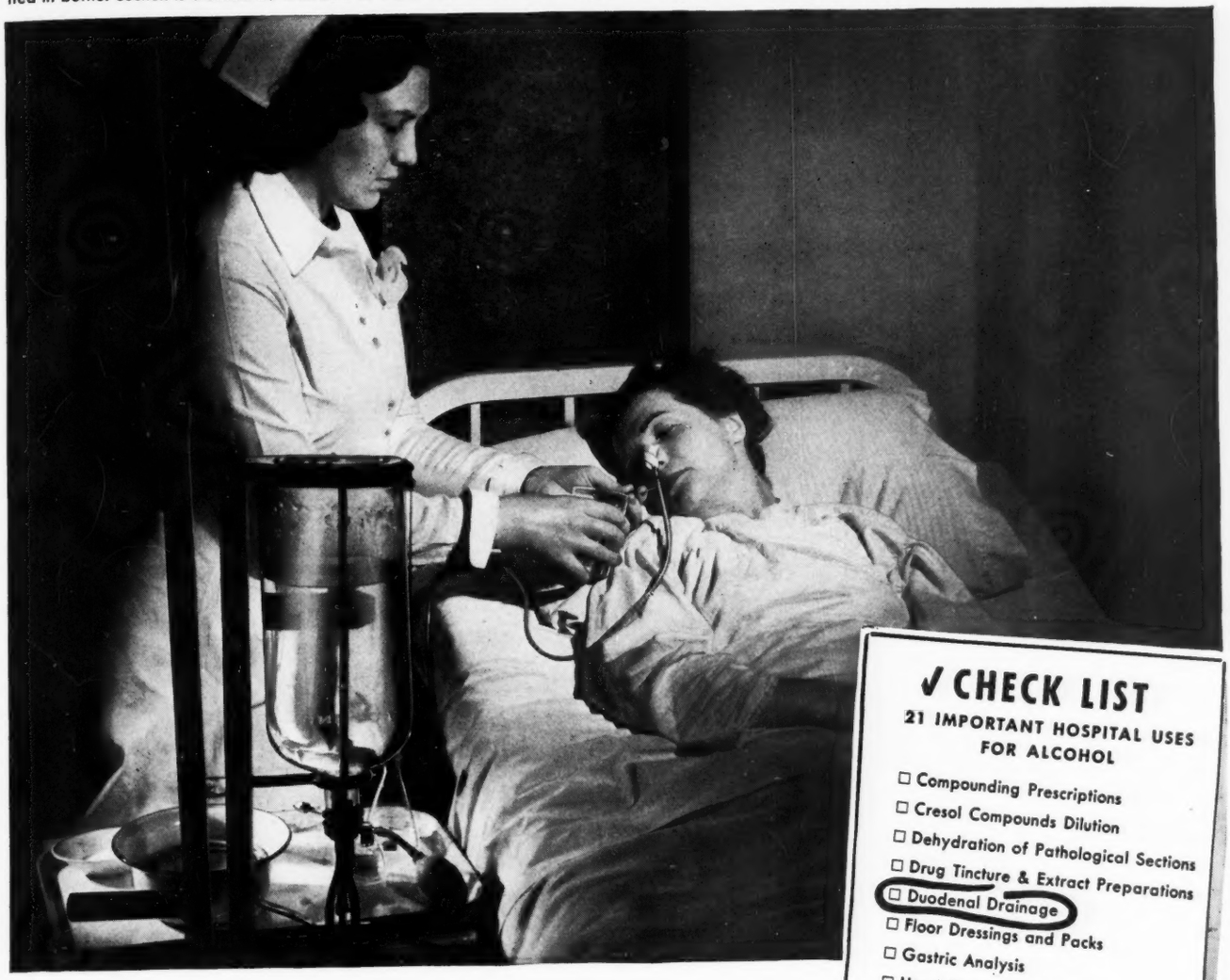

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Johnson Given Wellcome Award

The Sir Henry Wellcome gold medal and prize of $500 for 1940 has been awarded to Capt. Lucius W. Johnson, Medical Corps, U. S. Navy. Captain Johnson was granted the award on the basis of his essay on the subject of "Medical and Sanitary Care of the Civilian Population Necessitated by Attacks From Hostile Aircraft." Other awards to Captain Johnson in the past have included the Navy Cross for relief work in Santo Domingo, in 1930, and the Kober prize and lectureship on the subject of plastic surgery, in 1936.

Employes Demand 40 Hour Week

The board of public welfare of Minneapolis has agreed to make a survey to determine the cost of adjusting working hours of the employes of Minneapolis General Hospital in accordance with their demands for a forty hour week. The employes, who are enrolled in the C.I.O. union, estimate that the cost of the shorter week, through the employment of additional personnel, will cost approximately $76,000 a year. The survey will be made by Nathan Harris, city utilities engineer, and Dr. D. W. Pollard, superintendent of the hospital, with an official designated by the union participating.

Triboro Hospital to Open on January 1; New Clinic Started

Admission of patients to the new Triboro Hospital in New York City has been authorized by Mayor F. H. La Guardia for January 1. Although the patient census will be small at first, it is expected to reach the maximum of 557 by July 1. The hospital, which is a tuberculosis institution, features a day camp located on the ninth floor. It has been especially designed for use by outpatients who are well enough to be discharged from the hospital but who, because of unsuitable home conditions, require supervised convalescent care.

The cornerstone of the Kings County Hospital dispensary in Brooklyn, third of the series of 10 new clinics planned by the department of hospitals, was laid on September 25. The dispensary will be a five story steel and concrete structure and will relieve the overcrowded conditions at Kings County Hospital, where clinic visits increased from 163,638 in 1933 to 359,072 in 1939.

Bequest to Jewish Hospital

The sum of $198,519 was awarded to the Jewish Hospital in Philadelphia to build a new nurses' home when a distribution schedule of the estate of Mrs. Mary H. Hirsh was filed.

Infantile Paralysis Cases Up

The number of cases of infantile paralysis reported so far for 1940 shows a one third increase over the same period in 1939 and a five-fold increase over 1938, Basil O'Connor, president of the National Association for Infantile Paralysis, told a New York World's Fair audience recently. Mr. O'Connor, who was presented with the Goodrich award for distinguished public service, stated that the 7000 cases reported this year have been due largely to epidemics in six states. The national foundation has made available to those states doctors and nurses to care for the patients and splints and frames to reduce as far as possible the crippling after-effects.

Civilian Medical Officers Needed

An appeal for 600 civilian medical officers to serve in various grades for temporary or part-time service has been issued by the U. S. Civil Service Commission. Part-time medical officers will be able to continue their regular practice. Appointments will be made from physicians who live in the vicinity of the place in which they will serve. The expansion of the Army has created the need for these officers and their work will be important to the success of the national defense program.

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Most institutions immediately inform the Bureau when they foresee the need for an additional staff member; and the Bureau immediately assists them in deciding upon the conditions and necessary qualifications.

Medical and hospital people throughout the country have submitted their complete records and testimonials to the Bureau so that it can always furnish up-to-date informative biographies on any type of professional worker in the field.

By submitting your requirements to The Medical Bureau, you prepare for quick action in case of need. Write the Bureau today about your placement problem and let us send you one of our enrollment forms. Or, tell us about the people you need to complete or improve your staff.

The MEDICAL BUREAU

THE CONNECTING LINK BETWEEN MEDICAL ORGANIZATIONS SEEKING HIGHLY QUALIFIED WORKERS, AND SELECTED WORKERS SEEKING CAREERS IN THE MEDICAL FIELD

PALMOLIVE BUILDING, CHICAGO

Quarterly Report Shows Gain of 407,000 Members in Hospital Service Plans

A total of 5,607,000 persons are now protected by the 66 approved hospital service plans, according to the October 1 tabulation made by C. Rufus Rorem, executive director of the Commission on Hospital Service.

This represents a gain of 407,000 subscribers since the previous quarterly tabulation on July 1. During the first quarter of the year the approved plans (which then numbered only 56) gained a total of 371,000 members. In the second quarter the gain was 377,000 members and during the third quarter the gain was 427,000.

A considerable part of the larger gain in the third quarter was explained by the recent approval of seven plans. These plans are in Savannah, Ga.; Chapel Hill, N. C.; North Dakota; Portsmouth, Ohio; Oklahoma; Roanoke, Va., and Huntington, W. Va., and had a total membership on October 1 of 173,000. Hence, the other approved plans made a net gain during the period of 204,000. New York City, however, had a net loss of 23,000 subscribers for the quarter.

Plans with a net gain of 10,000 subscribers or more during the quarter were: Pittsburgh, 29,000; Minnesota, 26,000; Cleveland, 19,000; Philadelphia, 18,000; Michigan, 17,000; Chicago, 14,000; St. Louis, 12,000, and Newark and New Haven, 10,000 each.

A new commercial plan for employes of the Carnegie-Illinois Steel Company, Gary, Ind., was announced recently. The plan covers a loss of time indemnity from sickness or injury; a "principal sum" indemnity for loss of life, or of limbs or sight, and a surgical or obstetrical indemnity, as well as a hospital care protection.

For hospital service the plan will pay $4 a day plus a maximum of $20 for extras. Hospital service is available for fourteen days for obstetrical cases and for thirty-one days for other conditions. The price for employes earning less than $1800 per year is $1.50 per month for single employes, $2.50 per month for those with one dependent and $3 per month for those with more than one dependent. Higher rates are charged to employes earning larger incomes and their weekly and "principal sum" indemnities are increased. Nonprofit hospital service plans are not allowed in Indiana under existing state laws.

Coming Meetings

Nov. 8-9—Kansas State Hospital Association, Lamer Hotel, Salina.

Nov. 13—Colorado Hospital Association, Denver.

Dec. 5—Utah State Hospital Association, Salt Lake City.

Feb. 26—Texas Catholic Hospital Conference, Galveston, Tex.

Feb. 27-March 1—Texas Hospital Association, Adolphus Hotel, Dallas.

March 3-6—Association of Western Hospitals, Fairmont Hotel, San Francisco.

March 12-14—New England Hospital Assembly, Hotel Statler, Boston.

April 16-18—Hospital Association of Pennsylvania, Bellevue-Stratford Hotel, Philadelphia.

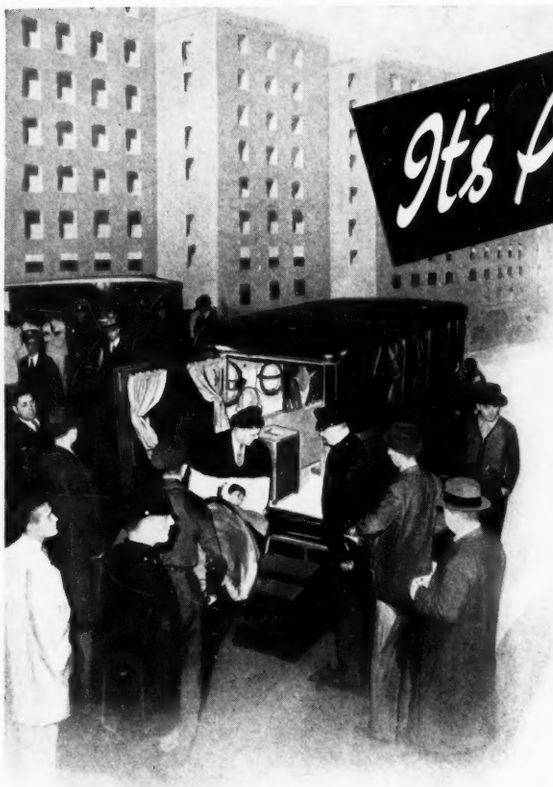
April 21-23—Iowa State Hospital Association, Fort Des Moines Hotel, Des Moines.

April 24-25—Mid-West Hospital Association, Kansas City.

April 29-May 1—Ohio Hospital Association, Deshler-Wallick Hotel, Columbus.

Device to Mix Oxygen and Helium

A new apparatus for the therapeutic administration of helium mixed with oxygen has been designed by the U. S. Public Health Service. Separate tanks of the two gases are used and devices have been contrived that regulate the correct proportion of the mixture and the volume of flow.



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● A sturdy, dependable apparatus for field and hospital emergency use in cases complicated by respiratory failure.

1. Extends the important advantages of the negative pressure principle of artificial respiration to include emergency service.
2. Readily adaptable for child or adult patients.
3. Operates by simplified hand manipulation when electric current is not available.

A VALUABLE ADDITION TO A WELL EQUIPPED EMERGENCY SERVICE

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ALL OUR PATIENTS ARE RESTING BETTER

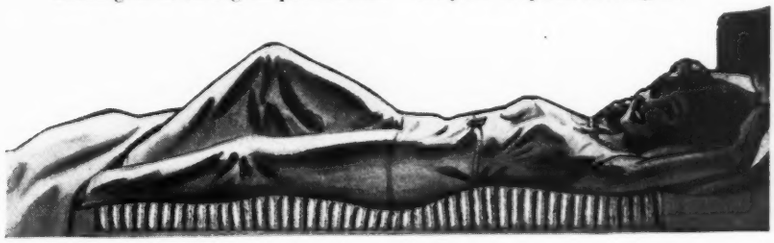
on U. S. ROYAL FOAM mattresses

● THIS NEW PRINCIPLE IN BODY SUPPORT has proved itself in hospitals from coast to coast. It substitutes for dead padding a mattress material of *live resiliency* far more responsive to body weight *and shape.* The U. S. Royal Foam mattress is molded in one piece of ODORLESS foamed latex. There's nothing in it to sag or pack down. Millions of connecting air pores provide a more even, buoyant support as well as hygienic self-ventilation. This 100% porosity makes the *entire mattress easy to sterilize*—or launder!

And the sag-proof permanence of U. S. Royal Foam mattresses means substantial economies for your hospital. *Investigate.*

Save Money on Mattresses

This interesting U. S. Royal Foam booklet shows you how. Write for your copy today.



UNITED STATES RUBBER COMPANY MISHAWAKA, INDIANA

New Orleans Is Host to Second Southern Institute for Hospital Administrators

The second southern institute for hospital administrators, sponsored by the American College of Hospital Administrators in cooperation with the Southeastern Hospital Conference, the Carolinas-Virginias Hospital Conference, Tulane University and Louisiana State University, was held in New Orleans, October 21 to November 1. Participating institutions in the sessions were Charity Hospital, which was host to the group, Touro Infirmary, Southern Baptist Hospital, Mercy-Soniat Memorial Hospital, Hôtel Dieu, French Hospital, United States Marine Hospital and DePaul Sanitarium.

Field trips were made to these hospitals to allow the students to witness demonstrations of hospital procedures. The demonstrations were tied in with the subjects covered in the morning lectures and evening round tables.

Among the speakers were Dr. Max M. Lapham, dean of the school of medicine, Tulane University; Dr. B. I. Burns, dean of the school of medicine, Louisiana State University; Dr. S. J. Hall, executive officer, U. S. Marine Hospital, New Orleans; Regina Kaplan, R.N., Leo N. Levi Memorial Hospital, Hot Springs, Ark.; Arden E. Hardgrove, Norton Memorial Hospital, Louisville, Ky., and other authorities in the field.

Call Meeting of Hospital Plans

The commission on hospital service has called a meeting of the hospital service plans in Chicago on November 9 and 10 to discuss the formation of a permanent organization of plans interlocked with the American Hospital Association. The report of the committee on organization which was presented by M. Haskins Coleman, chairman of the committee and director of the Richmond Hospital Service Association, Richmond, Va., at the Boston convention has been modified somewhat and will be used as the basis for discussion.

Lake Forest to Start Campaign

A campaign to raise $250,000 for a new hospital in Lake Forest, Ill., will shortly be under way, it was announced recently by Joseph M. Cudahy, chairman of the committee to build a new hospital. The new building is proposed to augment the inadequate facilities of the Alice Home Hospital and will be erected on a 24 acre tract of land donated by Mrs. Albert B. Dick. The hospital will cost approximately $400,000.

Navy Ships 500 Bed Mobile Hospital Unit to Cuba

A 500 bed mobile hospital that can be rushed to any outpost in the Western Hemisphere where American fighting forces may need hospital care has been shipped to Cuba. The hospital, complete with operating room, x-ray, dental and laboratory equipment, was packed in crates and shipped by freighter.

Practice in getting the hospital ashore, unpacking it and setting it up completely, tearing it down, repacking and loading it on board ship will occupy the officers and men of the unit for the next few months. Capt. Lucius W. Johnson, commanding the hospital, stated that he hopes to know by January 1 just how swiftly this can be done.

Franklin Hospital Pays Debts

Members of the Hennepin County district court, Minneapolis, were startled when A. G. Stasel, receiver for the Franklin Hospital, Minneapolis, requested permission to pay off 20 per cent of the claims on the institution. Mr. Stasel reported that since the hospital went into receivership five years ago, 40 per cent of the claims have been paid. He stated also that business operations are so successful that the institution has a net income of $10,000.

Names in the News

Administrators

Doctor Willard C. Rappleye, dean of the College of Physicians and Surgeons, New York, has accepted the appointment as commissioner of New York City hospitals to finish out the remaining fifteen months of Dr. S. S. Goldwater's term. Doctor Rappleye is one of the leading authorities on hospital administration and has held many positions as teacher and administrator. In 1938 he was elected president of the Association of American Medical Colleges and last year, president of the Advisory Council on Medical Education. Since 1937 he has been president of the Advisory Board for Medical Specialties. While he is commissioner of hospitals, Doctor Rappleye will also continue to guide the educational program of the college.

Thomas T. Murray, superintendent of Memorial Hospital, Albany, N. Y., has resigned that position to accept a similar post at White Plains Hospital, White Plains, N. Y., where he will succeed Frederick C. Sharp. Mr. Murray served as head of the Saskatoon City Hospital, Saskatoon, Sask., for six and a half years, after which he came to the United States to become director of the General Hospital, Knoxville, Tenn. Fourteen months later he took over the superintendency of the Albany institution.

Dr. Nathan Kraemer, a New York City physician, has been appointed head of the new Mount Sinai Free Clinic, which was formally opened on October 20. The clinic is an addition to the Mount Sinai Hospital and includes 15 medical departments.

Elizabeth Miller, superintendent of Paul Kimball Hospital, Lakewood, N. J., resigned on October 1. Miss Miller had served the institution for nine years.

A. C. Seawell, assistant superintendent of Baylor University Hospital, Dallas, Tex., was recently elected superintendent of the new City-County Hospital, Fort Worth, Tex. He assumed charge on October 15. Mr. Seawell is president of the Dallas County Hospital Council and is active in the Texas Hospital Association where he heads the council on association development.

Mrs. Olive Hubbard has been appointed superintendent of Brookfield Hospital, Brookfield, Mo., to succeed Frances Reinish, who recently resigned.

Dr. Thomas Howell, superintendent of Overlook Hospital, Summit, N. J., for the last four years, submitted his resignation to the board of trustees in September to take effect as soon as his successor can be appointed. Doctor Howell was formerly head of the New York Hospital, New York.

Dr. Robert C. Woodman has retired as head of Middletown State Hospital, Middletown, N. Y., a position he has held for the last seventeen years. Doctor Woodman was associated with the hospital for forty-two years, entering the institution as an intern in 1898.

Dr. Horace G. Ripley, superintendent and physician-in-chief of Brattleboro Retreat, Brattleboro, Vt., resigned on October 15. Doctor Ripley had been head of the institution since 1922. Prior to that he was superintendent of Boston Psychopathic Hospital, Boston.

Helen C. Doherty, superintendent of Martha's Vineyard Hospital, Oak Bluffs, Mass., tendered her resignation to the board of trustees of the hospital on October 25. Miss Doherty has been at the island hospital for twelve years.

CANNED FOODS AS SOURCES OF THE ESSENTIAL NUTRIENTS

● Early in this century, the existence of "accessory food factors"—the vitamins—was demonstrated by animal experiments (1, 2). Since that time, building upon information established by earlier investigators regarding the calorie, protein, and mineral needs of man, contemporary workers have developed a practical and fairly complete working knowledge of nutrition. At the present time, the fundamental human dietary requirements are considered in terms of some thirty substances of known chemical composition plus a number of factors whose chemical natures still await determination (3). Likewise, the dietary values of foods also may be discussed in terms of these same essential nutrients.

Viewed from a physiological basis, nutritional failures appear to be conditioned either by consumption of a diet deficient with respect to certain of the essential food factors or to altered processes in metabolism which prevent the efficient absorption and utilization of foods (1). Failures of the latter type can be corrected only by elimination of the defects in metabolism, or by administration of nutrients by routes which permit utilization. However, the vast majority of nutritional failures are associated with the consumption of diets deficient with respect to essential food factors. In the following quotation, the facts regarding malnutrition resulting from faulty diet are concisely stated (1):

> "Three facts concerning nutritive failure are becoming increasingly obvious: first, that it does not come solely from lack of vitamins but from deficiency of proteins and minerals as well; in certain of the lower animals, it comes even from lack of fats; second, that in America it is seldom complete; and third, that it is not, as a rule, the expression of a single nutritive fault. More often it is partial in extent and multiple in nature, with a clinical picture that is correspondingly lacking in detail and hazy in outline."

Although nutritional diseases are manifestations of the prolonged consumption of diets deficient with respect to amino acids, minerals, and vitamins, students of the problem agree (2, 4, 5, 6) that elimination of malnutrition is primarily a problem of increasing the variety of foods regularly eaten. Special emphasis should be placed upon the judicious consumption of familiar foods such as meats, (including glandular organs, poultry, sea food, and fish); eggs; milk in its many forms; milk products; fruits and vegetables; legumes; and the whole cereals and their various products. Thus, in its practical application (7), nutrition may be viewed as "an economic, agricultural, industrial and commercial problem, as well as a problem in physiology."

The nutritive values of canned foods have indeed been well established by means of numerous studies (8). By transforming foods, from the perishable condition in which they are harvested, to canned foods which may be stored for consumption in all seasons, the canning industry has rendered great assistance in carrying out the program designed to eliminate malnutrition in America.

AMERICAN CAN COMPANY

230 Park Avenue, New York, N. Y.

REFERENCES

1. 1939. J. Am. Med. Assoc. 112, 2110.
2. 1938. J. Am. Med. Assoc. 111, 1073.
3. 1940. J. Med. Assoc. Alabama 9, 365.
4. 1940. J. Am. Med. Assoc. 114, 548.
5. 1939. U. S. Dept. Agri. Circular No. 507.
6. 1938. J. Am. Med. Assoc. 111, 1846.
7. 1935. Quart. Bull. Health Organ. League of Nations 4, 326.
8. 1939. Canned Food Reference Manual, American Can Company, New York.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-fifth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

Dr. Lewis B. Galison was recently appointed assistant director of the Jewish Hospital of Brooklyn, N. Y., to succeed Dr. Dennison Young. Before this appointment, Doctor Galison was a member of the administrative staff of Sea View Hospital, Staten Island, N. Y.

Dr. Frank C. Sutton, formerly of Evanston Hospital, Evanston, Ill., has been named assistant superintendent and director of the out-patient department of St. Luke's Hospital, Cleveland.

Dr. Ralf Hanks, superintendent of State Hospital No. 2, St. Joseph, Mo., has been transferred to State Hospital No. 1 at Fulton, Mo., changing places with Dr. J. W. Bunch, who will take over Doctor Hanks' duties as head of the St. Joseph institution.

Harriet T. Blanch, R.N., superintendent of Aroostook Hospital, Houlton, Me., has accepted the position of superintendent of Walso County General Hospital, Belfast, Me. She will succeed Mrs. Muriel M. Avery, who resigned.

Ronald Yaw, who has been acting director of Blodgett Memorial Hospital, Grand Rapids, Mich., since January 1940, was appointed director of the institution on October 7.

Dr. August E. Witzel, acting medical inspector of the New York State Department of Mental Hygiene, has been appointed superintendent of the Newark State School, Newark, N. Y. He succeeds Dr. Hiram G. Hubbell, who has been serving as acting superintendent since the death of Dr. Charles L. Vaux in August 1938. Doctor Hubbell will resume his former position as clinical director of the institution.

Department Heads

Shirley Nickloy, R.N., has been made director of nurses at Battle Creek Sanitarium, Battle Creek, Mich. She succeeds Leone Sweet, who is on leave of absence from the hospital.

Beatrice Elizabeth Ritter took over the position of superintendent of nurses at Binghamton City Hospital, Binghamton, N. Y., on October 15, succeeding the late Letha M. Coger. Miss Ritter was formerly dean of the school of nursing at Temple University, Philadelphia.

Deaths

Helen Eddleston, superintendent, Community Hospital, New Prague, Minn., died September 11 after two weeks' illness. She had been head of the hospital for eleven years.

Anna M. James, R.N., superintendent of nurses at United Hospital, Port Chester, N. Y., died at Post-Graduate Hospital, New York City, after a short illness. Miss James had been head of the nursing department since last May.

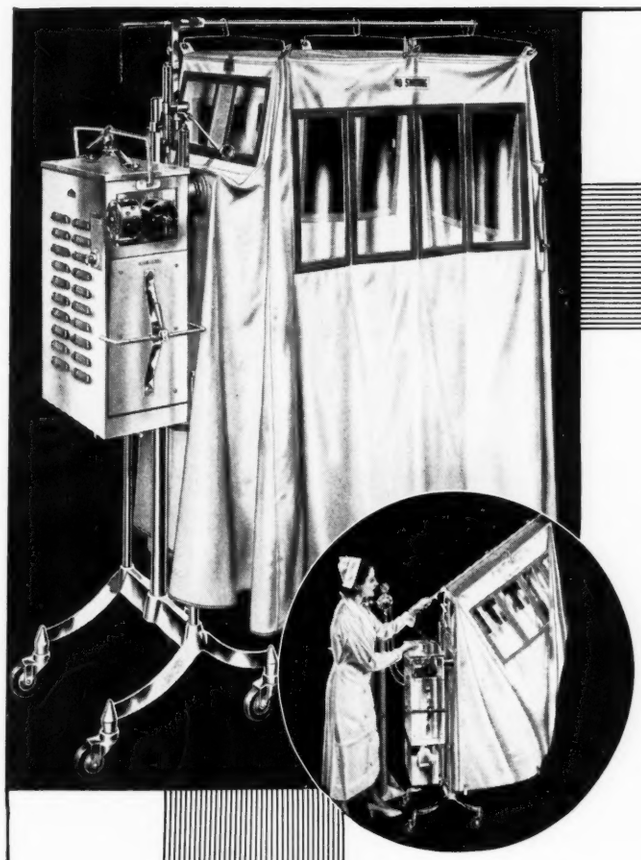
Margaret Fowler, R.N., director of nurses at Methodist Hospital, Philadelphia, died September 17 after an illness of several months. Miss Fowler had been associated with the hospital since 1907; she was appointed head of the nursing department in 1929.

Personnel Management Studied by Denver Hospital Officials

Approximately 50 administrators and department heads of Denver hospitals are attending a course in personnel management organized by the extension division of the University of Colorado and sponsored by the Denver Hospital Council. Some of the topics studied by the class include the nature of personnel problems and the status of labor; the nature and function of management; personnel management; technic of selection and placement, and maintenance of personnel.

The fees charged are $10 for noncredit students and $12 for credit students. Classes are held at St. Joseph's Hospital.

Another course in personnel management for ward supervisors is being given by the nursing extension division of the university.



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Oxygen Tents

When you consider the installation or replacement of Oxygen Therapy apparatus, it's important to know that an impressive majority of physicians and nurses who use the equipment in leading hospitals all over America, enthusiastically approve and endorse Heidbrink's dependability, efficiency and economy.

Heidbrink Oxygen Tents safe-guard the patients' welfare by the easily and accurately controlled oxygen supply, proper circulation and cooling, and the correct limitation of carbon-dioxid and humidity in the oxygen-rich air to be breathed. Their light, spacious hoods eliminate any tendency toward claustrophobia.

There Are Four Models From Which To Choose

One model is motorless . . . three are motorized. All are highly efficient, economical and embody many improvements and convenient features you'll appreciate. There are no handling or mechanical problems . . . any nurse can operate easily without assistance.

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Gentlemen:
Please send me descriptive literature on Heidbrink Oxygen Therapy Apparatus.

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Trade News

Paging With Intercommunication

• A combination paging and intercommunication system whereby the central master station can page independently over any one remote station or all remote stations simultaneously or can carry on a two way conversation with each station has been announced by Webster-Chicago Corporation, 5622 Bloomingdale Avenue, Chicago.

Catalog of Surgical Specialties

• The Clay-Adams Company, New York City, has just released a catalog describing Cacoprene and Calatex catheters, drains, tubes and rubber surgical specialties. Both Cacoprene and Calatex are made of synthetic rubber especially compounded to resist heat, oxidation, sunlight and chemicals.

Detention Netting

• The strength of steel without the bars is afforded by the new stainless steel detention netting recently put on the market by the Chamberlin Metal Weather Strip Company, Detroit. The netting is said to give a maximum of air and light and to protect patients from injuring themselves. The screens may be removed from the inside for window cleaning.

Tumor Record Forms

• Record forms covering 23 types of carcinoma have been prepared and recommended by the committee on the treatment of malignant diseases of the American College of Surgeons and published by Physicians' Record Company, Chicago. The forms are designed for tumor clinics and private practice records. A master form to be used for malignant tumors in regions for which no specific forms have been prepared is also included.

Reference Manual

• Becton, Dickinson & Co., Rutherford, N. J., is offering a new illustrated manual on the selection and care of syringes, needles, thermometers and bandages.

Painting Handbook

• The "Maintenance Painting Handbook," a 128 page manual offering solutions to various industrial painting problems, is now being distributed by the Industrial Paint Clinic of Chicago, which was recently established by the American-Marietta Company, Chicago. Indexed for quick reference, the book contains descriptions of surface preparation, methods of paint application and types of paints that have proved successful under widely varied conditions.

"Livable" Furniture

• A handsome 112 page catalog of institutional furnishings has recently been published by Hill-Rom Company, Batesville, Ind. The book, which contains color illustrations, is divided into several sections covering rooms for private and semiprivate patients, nurses, interns and ward patients, as well as supplementary and utility pieces and furniture for public rooms.

Personal Notes

• A new four story plant has been put into operation in Brooklyn, N. Y., by the Continental Coffee Company, Chicago. All the company's accounts east of Cleveland will hereafter be handled from the new Eastern headquarters. . . . Bardco Manufacturing and Sales Company, Los Angeles, has established a new plant in Dayton, Ohio.

Books on Review

NURSING IN SICKNESS AND IN HEALTH. *By Harriet Frost, R.N. New York: The Macmillan Company,* 1939. *Pp.* 213. $2.

This volume is one of the outstanding contributions of the last decade in the field of nursing education. In an orderly manner, the author outlines for the student carefully planned experiences that progressively bring her to a fuller understanding of her patient as a person and as a member of the family group and that acquaint her with the social, economic and emotional aspects influencing the patient in both hospital and home. Emphasis is given to the nurse as a teacher in the prevention of illness and promotion of health as well as a participant in the care of illness.

In the last four short chapters, the author deals with "the social aspects of nursing in the curriculum" and describes clearly and briefly the actual plan as it has been developed in the school with which she is associated. She suggests methods that are practical, provides case reports as illustrative material and urges full utilization of the rich resources for teaching that are to be found in the hospital, the out-patient department and the community.

A refreshing philosophy of human relationships, reflecting the author's own inimitable qualities, permeates the whole book. Welcome, indeed, is this valuable guide for teachers and administrators alike who are in search of assistance in making effective the recommendations of the Curriculum Guide that relate to health and to the preventive and social aspects of nursing education.—EULA B. BUTZERIN.

THE UNSEEN PLAGUE—CHRONIC DISEASE. *By Ernst P. Boas, M.D. New York: J. J. Augustin, Inc.* 1940. *Pp.* 121. $2.

Our aging population will ultimately bring about a marked increase in the incidence of chronic diseases. Recognition of this fact and a widespread interest in social security problems make the publication of this volume very timely.

The appearance of Doctor Boas' "Challenge of Chronic Diseases" in 1929 posed the problem nicely, but it is only recently that real interest has been evinced in this great mass of neglected and undifferentiated cases of chronic illness. The medical, social and economic aspects; the inadequacy of existing community facilities, and the need for further exploration and interpretation of the problem in the light of newer concepts are presented in a logical and lucid manner. Much still remains to be said on the ultimate responsibility of philanthropy and hospital authorities of both acute and chronic hospitals in association with government in the care and support of these patients.—J. MASUR, M.D.

GRAPHIC PRESENTATION. *By Willard C. Brinton. New York City: Brinton Associates,* 1939. *Pp.* 512. $5.

This unusual book contains hundreds of illustrations of different types of graphs and charts suitable for presenting a great variety of statistical data. There are legends under most of the examples but, otherwise, little text. Unlike the Modley book on "How to Use Pictorial Statistics," relatively little discrimination is made among the various types of graphic presentation methods. Each, to the author's way of thinking, has a purpose. Hospital administrators will find it interesting to study the wide variety of charts presented, many of which can be adapted to use in hospital work.—ALDEN B. MILLS.

Reader Opinion

Seek Aid for British

Sirs:

The situation in England is one of intense suffering. Surgical instruments and equipment are urgently needed now. Will you please help me to help the doctors, surgeons and hospitals at home to relieve this suffering by publishing this letter and the accompanying list of instruments? This list has recently been flown across to me by Clipper, from a source of highest authority in London.

The instruments and equipment that are most urgently needed in British first aid stations are as follows:

Airways, endotracheal; apparatus, anesthesia (portable); apparatus, intravenous; aspirators; autoclaves.

Cabinets, instrument; cannula, brain exploring; catheters; chisels, bone; clamps, bone plating; clamps, intestinal; clips, towel; crutches; curettes, mastoid.

Diagnostic sets; drills, bone; drills, cranial; elevators; forceps, artery (all types); forceps, bone (rongeur).

Gags, mouth (Denhart); gorgets, lithotomy; gouges, bone; headbands, metal, with mirrors; hemostats, all types; holders, needle; inhalers, chloroform; knives.

Lamps, operating, emergency (complete); mallets, metal, lead-filled; mirrors, laryngeal; pharyngoscopes with battery in handle; plates, bone; pliers, side cutting (6 inch); probes, all types; retractors, all types; rings, laparotomy.

Saws, all types; scissors, all types; screws, bone plating; shears; snares; sounds, metal; spatulas; speculums, ear, eye, nasal, rectal; sphygmomanometer, aneroid; splints; sterilizers, all types; stethoscopes; stools, anesthetists' (revolving); stools, foot; syringes, all sizes with needles; stretchers.

Tables, instrument; tables, operating; trocars; tubes, tracheotomy; wax, bone, sterile; buckets; clippers, hair; cups, medicine; jugs, graduated; measures, glass, graduated; bedpans, enamel; tables, bedside; urinals.

All contributions will be sent to England at once, where they will help save many lives that might otherwise be lost.

The Duchess of Leinster.
Bundles for Britain, Inc.,
745 Fifth Avenue, New York City.

Personnel Management

Sirs:

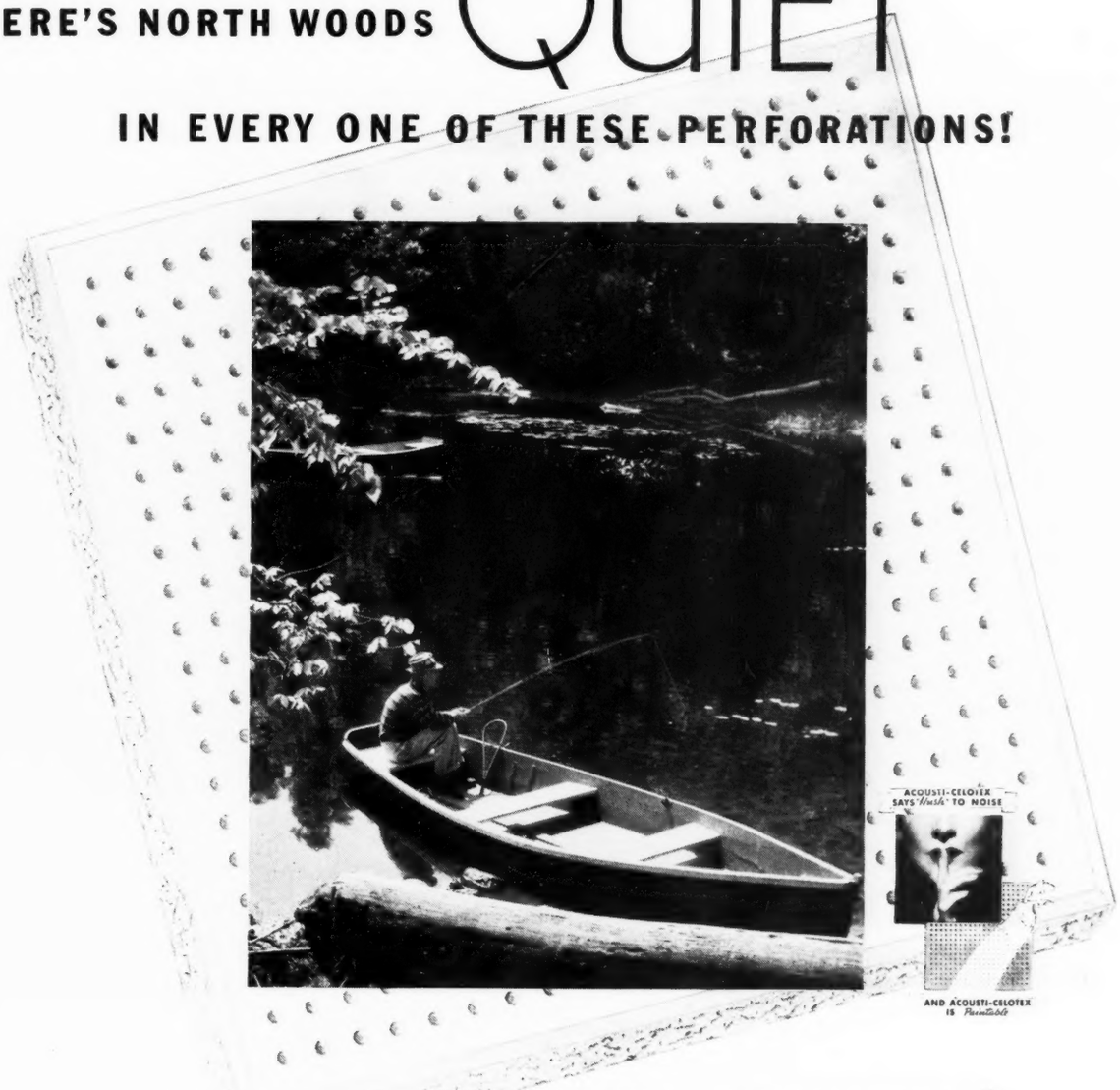
I am interested in obtaining information in regard to hospital personnel direction, particularly as concerns personnel records and hospital job analyses.

Charles H. Manlove, M.D.,
Superintendent.
Good Samaritan Hospital,
Portland, Ore.

An excellent new book, "Salary Determination," by John W. Riegel was recently published by the University of Michigan. This is a companion to his "Wage Determination," published in 1937. Job analyses were discussed and described as they apply to hospital workers in an article entitled "An Attempt at Job Grading" by Gertrud Kroeger in the fourteenth *Hospital Yearbook*, p. 78, and in an article entitled "Three Steps in Management of Personnel" by Nellie Gorgas in The Modern Hospital, October 1938. The recently published report by the American Hospital Association committee on personnel relations relating to job specifications for a hospital organization will be a useful tool for any hospital attempting a job analysis. One of the best general books on the subject is "Personnel Administration" by Ordway Tead and Henry C. Metcalf, published by McGraw-Hill in 1933.—Ed.

THERE'S NORTH WOODS QUIET

IN EVERY ONE OF THESE PERFORATIONS!



THAT'S WHY ACOUSTI-CELOTEX* CEILINGS ARE ABLE TO QUIET CORRIDORS, LOBBIES, DINING ROOMS

There is no question among hospital authorities about the many advantages of quiet. *It aids physicians and nurses by inducing complete rest for patients, hastening recovery.* That's why so many hospitals now use ACOUSTI-CELOTEX* ceilings to subdue noise in corridors, lobbies, dining rooms and nurseries.

Patented perforations in this modern sound-conditioning material *smother noisy echoes.* Their acoustical efficiency is not impaired by repeated painting or cleaning. ACOUSTI-CELOTEX can be installed *over old or new ceilings,* quickly and at moderate cost. An expert Noise Survey costs you nothing. Write today!

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Relaxatives

THE WAIL OF THE P.A.
(With Apologies to Ogden Nash and Arthur Guiterman)

If you think *your* vocation is trying,
Consider what a hospital is buying.
For here are the things you have to know:
The Superintendent told me so.
You have to know how to get things reasonable,
Whether in stock or out of seasonable.
You have to buy from the local boys,
For they can make a terrible noise
If you don't; because all the cash that they pay in-
To community chests they expect to make hay in;
Yet everything has to be inexpensive,
Whether orders are large or unextensive.
But here's what makes me want to shout:
I'm expected to know all things about:
Applicators, aspirators,
Tongue depressors, nurses' dressers,
Sterilizers, surgeons' visors,
Anesthetics, dietetics,
Window screens and lima beans,
Thermostats and rubber mats,
Mastic flooring, shelves for storing,
Surgeons' wipes, fittings, pipes,
Infants' cribs and babies' bibs,
Regulators, respirators,
Rubber sheeting, things for eating,
Window shades, gardeners' spades,
Engines, boilers, rags for oilers,
Gatch springs, rubber rings,
Gaseous mixtures, bathroom fixtures,
Razor blades, gowns for maids,
Cystoscopes and fracture ropes,
Cotton, gauze, drinking straws,
Soaps and powder, clams for chowder,
Butter, eggs, wooden legs,
Instruments, shirts for gents,
Knives and forks, druggists' corks,
Electric lamps, artery clamps,
Nurses' books, pots for cooks,
Keys and locks, timing clocks,
Pillow cases, flower vases,
Microbe slides and chair glides,
Buckets, pails, tools and nails,
Bakers, toasters, friers, roasters,
Tables, stretchers, pans for retchers,
Baby scales and bedside rails,
Door stops, porters' mops,
Nurses' calls, paints for halls,
Birds-eye diapers, window wipers,
Ligatures, pipe for sewers,
Rubber nipples, chairs for cripples,
Paper, pencils, ink, and stencils,
All these things, and hundreds more,
To mention which would be a bore.
So I spend all my days weighing quality and calory,
'Til sometimes I get so dizzy I actually wonder
Whether I cannot reduce the cost of my salary;
But to do that, I believe, would be very ridiculous,
For, after all, sometimes we can be *too* meticulous.

—JOHN H. HAYES.

Administrator's Fan Mail

• "Dear Dr.:

"If I may ask, understood charge nurse womans ward, you would call me back about 15th June. At present got a period as, I have been rather confused with so, much trouble don't know where I'm at. Would appreciate to know what to expect.

Yours."

• "Dear Sir:

". . . I had a stomach hernia for few years. It was 9 points above zero (strangled hernia). I did go to Hospital once about two years ago and stated I was taken care of by ..... They told me to go back as this end should be in their care.

yours truly."